Supreme Court, U.S.
FILED

961557 MAR 31 1997

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No. _____

In The

Supreme Court of the United States

October Term, 1996

JOHN E. CALHOON,

Petitioner,

v.

UNITED STATES OF AMERICA,

Respondent.

Petition For Writ Of Certiorari
To The Eleventh Circuit Court Of Appeals

PETITION FOR WRIT OF CERTIORARI

JOHN T. STRAUSS
Counsel for Petitioner
JOHN T. STRAUSS, P.C.
1132 Conyers Street
P. O. Box 1103
Covington, Georgia 30210
(770) 787-5020

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

73 pp

QUESTIONS PRESENTED

1. Since petitioner was deprived of a jury determination as to the critical element of materiality, which was not submitted to them, and hence clear error occurred, can such error ever be rendered "plain" or harmless, since petitioner was by that error deprived of his Fifth Amendment right to due process of law and his Sixth Amendment right to trial by jury?

2. Can petitioner ever be convicted of submitting false or fraudulent Medicare claims for monies actually and properly expended, regardless of intent, when the guidelines governing reimbursement relied upon by the Government to show falsity are non-binding and of presumptive validity only, and subject to adjustment under a fluid adjudicatory review system?

3. If the Government totally fails to prove as alleged objective falsity – that the Medicare claims at issue were in fact not reimbursable – can petitioner's conviction be affirmed on a theory of concealing that which may or may not have been false when not so charged in the indictment?

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[1] The parties to this action are those stated in the caption of the case, that is, John E. Calhoon, petitioner v. United States of America, respondent.

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I. JURISDICTIONAL STATEMENT

(a) Following a jury trial beginning on the 19th day of September, 1994, petitioner was convicted of eight counts of violation of 18 U.S.C. §1001 (false statements with respect to Medicare reimbursement claims for his employer, Charter Medical Corporation) (two counts were dismissed by the Government and the jury acquitted him of another) and three counts of violating 18 U.S.C. §1341 (mail fraud). Trial was held before the United States District Court for the Middle District of Georgia, Honorable Duross Fitzpatrick presiding, District Court Number 92-12-MAC (DF). Petitioner was sentenced on February 2, 1995 to a total term of imprisonment of fifteen months, followed by three years' supervised release and mandatory fines in the amount of $550.00, with the provision for 200 hours of community service (R. 132, R. Ex. Tab 3).

(b) Following post-trial motions, an appeal was filed by petitioner to the United States Court of Appeals for the Eleventh Circuit on July 12, 1995, Number 95-8171, which Court affirmed petitioner's convictions and sentence on of all counts in an opinion dated October 16, 1996, and reported in 97 F. 3d 518 (11th Cir. 1996) (Appendix A).

(c) Petitioner thereafter filed a motion for rehearing and a suggestion of en banc reconsideration, which motion and suggestion were denied by the Court by order dated December 30, 1996 (Appendix B). The present petition for writ of certiorari is filed within ninety days of the order denying the motion for rehearing, as required by this Court's Rule 13(1).

(d) Jurisdiction is conferred upon this Court by allegations of a direct violation of the Fifth and Sixth Amendments to the Constitution of the United States and 28 U.S.C. §1254. Jurisdiction in the Court below was based upon 28 U.S.C. §1291.

II. GOVERNING AUTHORITIES

No person shall be held to answer for a capital, or otherwise infamous crime, unless on a presentment or indictment of a Grand Jury, except in cases arising in the land or naval forces, or in the Militia, when in actual service in time of War or public danger; nor shall any person be subject for the same offense to be twice put in jeopardy of life or limb; nor shall he be compelled in any criminal case to be a witness against himself, nor be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation.

Fifth Amendment to the United States Constitution

In all criminal prosecutions, the accused shall enjoy the right to a speedy and public trial, by an impartial jury of the State and district where the crime shall have been committed, which district shall have been previously ascertained by law, and to be informed of the nature and cause of the accusation; to be confronted with the witnesses against him; to have compulsory process for obtaining witnesses in his favor, and to have the Assistance of Counsel for his defense.

Sixth Amendent to the United States Constitution

Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned not more than five years, or both.

18 U.S.C. §1001

Whoever, having devised or intending to devise any scheme or artifice to defraud, or for obtaining money or property by means of false or fraudulent pretenses, representations, or promises, or to sell, dispose of, loan,

exchange, alter, give away, distribute, supply, or furnish or procure for unlawful use any counterfeit or spurious coin, obligation, security, or other article, or anything represented to be or intimated or held out to be such counterfeit or spurious article, for the purpose of executing such scheme or artifice or attempting so to do, places in any post office or authorized depository for mail matter, any matter or thing whatever to be sent or delivered by the Postal Service, or deposits or causes to be deposited any matter or thing whatever to be sent or delivered by any private or commercial interstate carrier, or takes or receives therefrom, any such matter or thing, or knowingly causes to be delivered by mail or such carrier according to the direction thereon, or at the place at which it is directed to be delivered by the person to whom it is addressed, any such matter or thing, shall be fined under this title or imprisoned not more than five years, or both. If the violation affects a financial institution, such person shall be fined not more than $1,000,000 or imprisoned not more than 30 years, or both.

18 U.S.C. §1001

The reasonable cost of any services shall be the costs actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing a method or methods to be used and the items to be included, and in determining such costs for various types or classes of institutions.

42 U.S.C. §1395x(v)(1)(A)

Applicable portions of 42 C.F.R. 413 (Lodged Appendix Tab 1)

Regulations and Guidelines Governing Intermediary Review and Reporting Requirements (Lodged Appendix Tab 2)

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III. STATEMENT OF FACTS

All charges against the petitioner arose by virtue of his affiliation with Charter Medical Corporation during calendar years 1987 through 1989 (R. 63, Vol. 1, pp. 1-13). Macon, Georgia was headquarters for Charter Medical Corporation. Charter operated a national chain of different hospitals, although only some of the psychiatric hospitals were the subject of the indictment (R. 63, Vol. 1, pp. 1-3). Charter psychiatric hospitals provide treatment to qualified individuals 65 or older and certain disabled persons, and Charter would make claims for Medicare reimbursement for these treatment expenses to the Health Care Financing Administration (HCFA), an agency of the United States Department of Health and Human Services, by filing cost reports (R. 63, Vol. 1, p. 2; R. 116, Vol. 5, pp. 62-63). Petitioner's job description as reimbursement manager was the maximization of reimbursement of cash-flow from third-party payers (such as HCFA) to the company's hospitals (R. 131, Vol. 8, p. 57 and petitioner's Exhibit 18), and petitioner took an aggressive role in seeking reimbursement (R. 131, Vol. 8, pp. 58-59 and petitioner's Exhibits 15, 16, 17, 21; p. 68; p. 85; petitioner's Exhibit 20; pp. 75-76).

When cost reports claiming Medicare reimbursement were submitted by petitioner, his subordinates, and his peers to the Health Care Financing Administration, HCFA used a number of insurance companies, called in the trade "intermediaries," to review and as need be audit the cost reports to determine the amount of reimbursement that would be provided (R. 116, Vol. 5, pp. 63-64). The intermediaries would contract with HCFA to provide these review/audit services, subject to the overriding statutory guidance of whether the costs claimed were reasonably related to patient care, applying (when any did apply) duly enacted regulations of the Secretary of Health and Human Services, and also a set of policy decisions/guidelines called the Provider Review Manual, which were contractually binding as standards upon the intermediaries in their review process, but which were non-binding insofar as the provider hospitals were concerned (R. 116, Vol. 5, pp. 64, 69, 102).

A cost report filed on behalf of any of the Charter hospitals as provider required a statement of the total costs expended by the hospital for its operation for each category of expense, including costs for Medicare and non-Medicare patients alike. The next step was to determine what were deemed "allowable" costs for Medicare reimbursement purposes, with the intermediary disallowing types of costs that they deemed inappropriate under the regulations and guidelines; and then, to the total figures of "allowable" costs a percentage would be applied reflecting the percentage of total costs that were expended proportionally for Medicare patients, with the sum of these "allowable" item calculations in each category being the total amount of approved reimbursement (R. 116, Vol. 5, p. 69). The final cost reports were submitted for each hospital annually, on staggered fiscal year bases; but to recognize the solvency needs of the particular providers, estimated payments were made periodically during the year, with plus or minus adjustments made pursuant to the final annual cost report submitted (R. 116, Vol. 5, pp. 65-66).

By law, costs had to be actual, that is, no more than the amount expended; however, HCFA would reimburse only the lower of either actual costs or the charges for services (R. 116, Vol. 5, pp. 67-68).

The general statutory guideline was that costs would be allowable if reasonably related to patient care, were necessary and proper, and where customary in the industry for hospitals of the provider's type (see current codification as 42 C.F.R. §413 in Lodged Appendix Tab 1; R. 131, Vol. 6, p. 5).

When an intermediary was presented with a cost report, its representative would normally do a preliminary desk audit to determine whether a field audit was appropriate, based on the information from the provider, primarily by comparing items on the cost report to claims in prior years; if material differences appeared from prior years' reporting, then a field audit was normally undertaken, which involved examination of underlying cost data at the particular hospital or consultation with reimbursement personnel as appropriate. The auditors were provided with a detailed checklist of matters to review (R. 116, Vol. 5, pp. 71, 74-75, 85; Lodged Appendix Tab 2).

In order for the provider to preserve its right to challenge any anticipated or potential disallowance of any item of costs or part thereof, the provider had to include the item within the cost report (R. 131, Vol. 6, pp. 3-4 and D's Ex. 1). Intermediaries differ in what their representatives will deem allowable (R. 116, Vol. 5, p. 104), and if there was a debate whether the cost should be allowable, the provider could include the entire cost (R. 116, Vol. 5, p. 100).

After the intermediary has conducted whatever audit it deems appropriate, it issues a notice of program reimbursement to the provider (Lodged Appendix Tab 2), after which the provider has 180 days to work out through negotiation any issues of dispute with the intermediary, or appeal to an administrative body known as the Provider Reimbursement Review Board (R. 131, Vol. 6, p. 69).

As discussed more fully within, reporting requirements were to be based on books and records maintained by the provider (without any necessarily specified format or listing of accounts) in accordance with generally accepted accounting principles, which governed in the absence of regulations or guidelines as to issues of reimbursement.

The provider could and often did "self-disallow" some items for reimbursement purposes by making adjustments from the statement of total costs, on an adjustment page known as the "A-8" form (see generally the testimony of John Banfield, R. 131, Vol. 6, pp. 150-202). In addition, custom and practice, as well as generally accepted accounting principles and Securities and Exchange Commission regulations, required the preparation of reserve cost reports, kept internally, which reflected conservative net estimates of the amounts claimed for reimbursement, excluding amounts that would possibly be at least initially disallowed, so as not to overstate potential receivables or profits (R. 131, Vol. 8, p. 79; R. 131, Vol. 6, p. 171).

In addition to the general limitations on reimbursements discussed above, particularly the lower-of-costs-or-charges (R. 116, Vol. 5, p. 68), a major limitation upon the amount of reimbursement for a provider hospital was imposed by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Under TEFRA, a target amount was determined according to a hospital's cost reporting "base" period, usually the first full twelve-month reporting period of its history, which was used to determine a Medicare per-patient cost allowance for subsequent reporting periods, regardless of actual expense (R. 131, Vol. 6, pp. 37, 38-42). It was difficult to change the TEFRA target rate after it was established (R. 131, Vol. 6, p. 66).

It is within this framework that the present charges arose. The typical Charter cost report was supported by the summary general ledgers (called GL 280s) from the reporting hospital, containing 150 to 200 cost items (see, *e.g.*, R. 131, Vol. 6, p. 156 and Gov't. Exs. J3, J4, and J5).

Out of all these cost items in each of the reports, the Government claimed that JOHN CALHOON had filed or caused the filing of false cost reports with respect to only three items, variously asserted in the respective counts of the indictment as described within, to wit: royalty fees, "CMCI" interest, and advertising expense claimed under the title "Outreach." Except for the advertising/outreach issue, the Government's entire case as to interest and royalties rested on the testimony of an immunized former subordinate of the petitioner named John Banfield.

The items of proof as related to the counts upon which conviction was obtained can be summarized as follows:

COUNT	HOSPITAL/ YEAR	CLAIMED FALSITY
(a) 1 (§1341) and 9 (§1001)	Corpus Christi (1989)	Royalties and CMCI Interest
(b) 2 (§1341) and 12 (§1001)	Lake Charles (1988)	Royalties
(c) 3 (§1341) and 14 (§1001)	Charter Woods (1989)	Royalties
(d) 4 (§1001)	Charter Mobile (1987)	Advertising/ Outreach
(e) 5 (§1001)	Charter Springs (1987)	Outreach/ Advertising
(f) 6 (§1001)	Charter Tampa Bay (1988)	Outreach/ Advertising and Royalties
(g) 7 (§1001)	Charter Glade (1988)	Royalties and Outreach
(h) 13 (§1001)	Charter Woods (1988)	Royalties

REFERENCE

(a) R. 131, Vol. 6, pp. 183-86
(b) R. 131, Vol. 6, p. 175
(c) R. 131, Vol. 6, pp. 169-70
(d) R. 131, Vol. 7, p. 92
(e) R. 131, Vol. 7, pp. 108-09
(f) R. 131, Vol. 6, pp. 23-33
(g) R. 131, Vol. 6, pp. 199-202
(h) R. 131, Vol. 6, pp. 150-61

As to each of the cost reports in which royalties and/or CMCI interest was claimed by John Banfield, the substance of his testimony was that he did not know that royalty fees and CMCI interest were not allowable for Medicare reimbursement purposes; that he was instructed by JOHN CALHOON as his superior to claim royalties and CMCI interest as the issues arose for reimbursement purposes on the cost reports, but to recognize the probable disallowance of the claims by listing the amounts on the reserve cost reports; that as required the total cost to the respective hospital on each described cost report was shown, but that no self-disallowance occurred by an adjustment out of the Medicare usage portion applicable to each item; and that the percentage of each amount claimed that was reflective of the Medicare percentage was stated on the respective reserve cost report for that hospital and for that year. Although there were serious questions raised about Banfield's credibility, and although the petitioner denied instructing Banfield to claim either royalties or CMCI interest at any time, the jury chose to believe Banfield over the petitioner with regard to all charges except count 8 of the indictment. Petitioner freely admitted that he knew at all times relevant that royalty fees and CMCI interest were presumptively non-allowable for Medicare reimbursement purposes.

As to the advertising/outreach issue, petitioner freely admitted his efforts to claim advertising expense

under the title "outreach" in each of the years in question, maintaining he had a right to do so.

The parties stipulated that the three cost reports described in counts 1, 2, and 3 (the Section 1341 counts) were in fact mailed.

(1) *Royalties.* In an attempt to establish the nature of the royalty claims applicable to the above-stated counts of the indictment and cost reports to which they applied, the Government introduced the testimony of Linton Newlin, the person responsible for tax planning and related matters for Charter Medical Corporation (R. 131, Vol. 6, p. 142). Mr. Newlin freely admitted that he knew nothing about Medicare reimbursement or how the tax consequences of the transactions he described had any bearing upon reimbursement issues (R. 131, Vol. 6, p. 147). Mr. Newlin testified that Charter Medical Corporation had transferred the right to use the Charter name to a Nevada corporation that he had created called CMCI; that because Charter was a national corporation, the use of the name was good for the profitability of the respective hospitals, such that CMCI could justifiably charge a fee to the particular hospitals for use of the name, which would create an expense deductible by the hospitals; at the same time CMCI, being incorporated in Nevada which had no state income tax applicable to corporations, would increase its profits by consequent tax savings (R. 131, Vol. 6, pp. 143-45). He indicated that normally royalty fees were charged only one time; in 1988 royalty fee bills were sent to Charter Woods, Charter Lake Charles, Corpus Christi, Charter Glade, and Tampa Bay hospitals (R. 131, Vol. 6, p. 146 and Gov't. Exs. K-15 through K-19 inclusive).

The Government also produced the testimony of Bessie T. Wheeler, long-term employee of one of the intermediaries, as an expert witness (R. 116, Vol. 5, p. 92). It was her initial opinion that royalty fees were disallowed under a provision of the Provider Reimbursement

Manual Guidelines and that in addition the Code of Federal Regulations provision prohibiting cost to related organizations and the comparable provider manual guideline might also come into play (R. 116, Vol. 5, p. 97 and Gov't. Exs. K-12, and K-9). But Ms. Wheeler's testimony was further qualified to the extent that she agreed that an intercompany expense, if an actual expense, was allowable; if it were only a bookkeeping entry, then it was disallowed (R. 116, Vol. 5, p. 99). She also acknowledged that the guidelines she deemed applicable to the issue of royalty fees provided that royalty fees were allowable if reasonably related to patient care (R. 131, Vol. 6, p. 4 and D. Ex. 2). Mr. Newlin, the tax expert, had also testified that the money paid by the particular hospital for royalties to CMCI was real money out of the hospital's pocket, that is, actual expense to the particular hospital (R. 131, Vol. 6, p. 149).

The Government's expert, Ms. Wheeler, also testified that a cost will be allowable if reasonably related to patient care, if it were necessary and proper as an expense and recognized as a cost normally associated with hospitals of the type within the industry; and further, that it was a matter of opinion and evidence as to each hospital whether a cost is or is not, and how much of that cost, reasonably relates to patient care, except that in some areas the regulations and instructions were in her opinion pretty clear (R. 131, Vol. 6, pp. 4-5).

The Government made no attempt whatsoever to establish from the books and records of any of the hospitals at issue whether and to what extent royalty fee costs did or did not relate to patient care at that hospital, nor did the Government present any evidence or testimony other than what has been stated in any form or fashion to show in fact what the relationship of the royalty fees was to patient care. Instead, the Government relied on the testimony of Don Crossett (and the defendant's general admission of non-allowability of royalty fees) to the effect

that he told his staff as Charter head of reimbursement from 1981 through 1987 that no royalty fees were allowable (R. 131, Vol. 6, pp. 24-25).

The Court and jury were not told, however, that the Provider Reimbursement Manual guideline with respect to the allowability or non-allowability of royalty fees had been repealed in the early to mid-80s without a comparable replacement provision, and that subsequent guidelines simply dealt with how royalty fees should be reported when claimed (Lodged Appendix Tab 3). As the repealed guideline itself shows (D's Ex. 2, R. 131, Vol. 6, p. 4), it was primarily directed to franchise, as distinct from royalty fees – a situation not related to Charter, which did not franchise its name, but allowed the use of its name by its own hospitals.

At no time did the Government claim or attempt to show that the costs expended as royalties by Charter Medical Corporation hospitals were in fact not actual costs.

(2) *CMCI Interest*. The issue of CMCI interest, in accordance with the jury's findings, related to only one transaction (Corpus Christi 1989), as reflected in counts 1 (Section 1341) and 9 (Section 1001) of the indictment.

The tax expert for Charter, Linton Newlin, testified that the subsidiary corporation of Charter which he created in Nevada, CMCI, would obtain funds from various sources and would loan monies to the various hospitals, which in turn would pay back principal and interest to CMCI on the loans. The interest paid by the hospitals would be deductible for tax purposes by them and the profitability to CMCI by virtue of the interest paid would be increased because Nevada did not have any corporate state income tax (R. 131, Vol. 6, p. 143). Again, Mr. Newlin testified that the money paid for interest to CMCI was a real expense out of the hospital's pocket (R. 131, Vol. 6, p. 149). Mr. Newlin also testified that he did not know anything about the consequence of these transactions for

Medicare reimbursement purposes and did not know whether the internal Charter memoranda relating to its tax restructuring and planning concerning CMCI were ever sent to anyone in the reimbursement section, or to the petitioner particularly (R. 131, Vol. 6, p. 147).

The Government's theory was apparently that CMCI interest was a cost to a related organization (R. 116, Vol. 5, p. 97 and Gov't. Exs. K-7 and K-9). However, the Government did not address the fact that interest expense of some types is allowable for Medicare purposes (R. 131, Vol. 6, pp. 186-88; R. 131, Vol. 8, pp. 39-40; Lodged Appendix Tab 4); 42 C.F.R. 413.153(b)(2)). Instead, the Government attempted to establish illegality through the testimony of Don Crossett, former Charter head of reimbursement from 1981 through 1987, who testified that he told his staff that no CMCI interest was allowable, and who circulated a memorandum (which petitioner admittedly got and relied upon with regard to his actions), to the effect that the individual hospital should not claim CMCI interest because the home office cost report (Charter headquarters report) would internally claim this amount and allocate it to the particular hospitals (R. 131, Vol. 6, pp. 24-26 and Gov't. Ex. K-21). The memorandum at the time issued and circulated in late 1986 indicated that at that time the CMCI interest issue applied only to Texas hospitals (Gov't. Ex. K-21). Staff knowledge of the treatment of CMCI interest generally depended upon word of mouth, and Crossett himself never saw any detailed explanation of the CMCI interest issue (R. 131, Vol. 6, pp. 57-58). As did Mr. Newlin from a tax point of view, Don Crossett testified that in fact the interest paid to CMCI was a real expense to some entity, and that it was his understanding that internal Charter policy as expressed in his memorandum was an effort to avoid duplication of the claim by denying the individual hospitals internally the right to claim this expense because the

home office report would claim it (R. 131, Vol. 6, pp. 58-59).

At no time did the Government attempt to establish by testimony or evidence that CMCI interest was not a legitimate expense to the particular claiming hospital by rule or regulation; or that the taking of the CMCI interest expense as a reimbursement claim on the cost report of a particular hospital (as distinct from the home office report) was inherently illegal; or that the home office report filed with regard to year 1989 had been filed earlier than the Corpus Christi report at issue (or for that matter when the home office cost report was filed for that year), so that the claim would have been a duplication *at the time* the Corpus Christi cost report was submitted for reimbursement; or that CMCI interest expense to Corpus Christi was in fact not related reasonably to patient care. The Government also, as with royalty fees, at no time attempted to claim or show that the interest expense was not a real expense or that the Corpus Christi cost report attempted to claim anything more than actual costs and expenses. Also, once again, the Government did not attempt to present any testimony or evidence from personnel at Charter Corpus Christi familiar with the books and records of that hospital, to show the nature of the loan to which the claimed "non-allowable" interest related, despite the testimony of the Government's own expert that one needed to examine intercompany transfers to determine if they were real expenses (R. 116, Vol. 5, pp. 111-12).

(3) *Advertising/Outreach*. The testimony and evidence with regard to the advertising/outreach issue is totally different and distinct, as was the Government's theory, from the issues related to royalty fees and CMCI interest. Firstly, as shown by the outline of charges and issues set forth above, none of the claims for advertising expense reimbursement was a basis for any mail fraud

count; the Government contended only that the respective claims as documented were false, in violation of 18 U.S.C. §1001. Secondly, the petitioner never denied authorizing or claiming advertising expense under the title "outreach," asserting instead that he had the right to do so under applicable guidelines (R. 131, Vol. 8, pp. 58-59, 70, 68, 82, 85, 87-88 and D. Exs. 3 and 20). Thirdly, other than the statutory and regulatory standard that costs must be reasonably related to patient care, the only guidance with respect to advertising cost was provided by the non-binding Provider Review Manual (D. Ex. 3; Lodged Appendix Tab 5), which indicated that advertising costs were generally allowable if reasonably related to patient care, were primarily designed to advise the public of the services available through the hospital and to present a good public image, and were not primarily designed to increase patient census. Fourthly, the Government seemed to shift its approach at trial after the testimony of its own expert, Bessie Wheeler. Ms. Wheeler testified that advertising costs can be allowable or non-allowable; that the Provider Review Manual provides guidance of a non-binding nature; that one has to examine the individual ads to determine allowability under the standards/guidelines; and that whether particular advertising may or may not be allowable for Medicare reimbursement purposes is a matter of opinion (R. 116, Vol. 5, pp. 100-102, 115-16; R. 131, Vol. 6, pp. 4-5). As with the royalties and CMCI interest issues, the Government made absolutely no attempt to present any testimony from any personnel at any of the hospitals involved or to produce any of the advertisements, as they would have had to after Ms. Wheeler testified. The Government instead took the position that even though the petitioner might have the right to claim that all advertising expense was allowable and to contest the denial of reimbursement through the appeal process (Gov't.'s final argument, R. 131, Vol. 9, pp. 57, 59-60), the relevant cost report claims

for reimbursement of advertising expense were "false documents" because the petitioner chose to label the advertising expense as "outreach" (Gov't.'s opening argument, R. 131, Vol. 9, p. 22), even despite the fact that the Government had made no attempt to show whether in fact the advertising in question was appropriately considered outreach under traditional terminology previously used (such as in the context of alcohol outreach) by showing the ads and publications used by the respective hospitals (see Lodged Appendix Tabs 6 and 7). Instead, the Government at trial attempted to prove objective falsity indirectly by showing the history of disagreement between the petitioner and his subordinates and peers over his treatment of the advertising issue, and that his motives were to intentionally disguise the nature of the claims (see R. 131, Vol. 6, pp. 70-73, Gov't. Ex. K-28, pp. 90-92, Gov't. Ex. K-27; R. 131, Vol. 7, pp. 106-28, pp. 84-91). The Government particularly pointed to the petitioner's efforts to collapse all advertising subaccounts from the individual hospital general ledgers into one non-discriminating "outreach" category (although this in fact may have only shown up on a few cost reports actually filed). Despite this contention, the very witnesses upon whom the Government relied indicated that the intermediaries would cause a field audit to be done if there were material differences in the manner of reporting for that hospital from its reports in prior years (R. 116, Vol. 5, pp. 74-75); that because of Charter's aggressive approach toward claiming advertising, its cost reports were subject to increased intermediary scrutiny (R. 131, Vol. 6, p. 100); that the term "outreach" not only related to alcohol patients but also to advertising reaching out to those with drug and psychiatric disorders (R. 131, Vol. 6, pp. 71, 101); that the amounts for advertising reflected in the collapsed advertising/outreach category were the same as actual hospital expenses; and that putting all advertising into an outreach category was simply

something that the intermediary was not going to overlook (R. 131, Vol. 2, pp. 201-02, 205); and that Charter had a strong position that all advertising was allowable for psychiatric hospitals, and all advertising issues were clear-cut disputed issues for appeal purposes (R. 131, Vol. 7, pp. 69-70, 71).

The petitioner testified, without any direct contradiction in the evidence, that outreach as a description of advertising to advise the public of available services had been used as a clinical term since the 1970s (R. 131, Vol. 8, p. 82; Lodged Appendix Tab 7); that in fact as to count 4 of the indictment (Charter Mobile, the sole issue being advertising/outreach) that reporting and claiming advertising under the outreach name had, after field audit, resulted in 100% allowance of all advertising/outreach costs (R. 131, Vol. 8, p. 68; R. 131, Vol. 7, pp. 105-06 and Gov't. Ex. D-11); that in an earlier case using the same corporate counsel (Rick Shackelford) as Charter's attorney, a claim for 100% advertising/outreach reimbursement had been allowed through petitioner's efforts (R. 131, Vol. 8, p. 68); that the collapsed outreach ledger expressed the exact same amount of actual costs as the listed advertising accounts from the ledgers of the particular hospital (R. 131, Vol. 8, p. 70); that the auditor (based on petitioner's experience as an intermediary auditor) must look at prior years' cost reports for the same hospital to determine deviation in reporting practices and could not be deceived (R. 131, Vol. 8, p. 70); and that Charter's positions were well known to the intermediaries with whom they routinely dealt; and the same intermediaries would address the same positions and issues advanced by Charter from year to year (R. 131, Vol. 8, p. 86).

Except for the opinion testimony of petitioner's peers and the objected-to hearsay testimony with regard to the opinion of corporate counsel impliedly expressed through his recommendation/direction not to use the

collapsed outreach ledger described above, the Government made no attempt to show that in fact calling advertising outreach was inherently unlawful or that it was prohibited by any of the reporting rules, regulations, or guidelines applicable to Medicare reimbursement claims or, as stated above, that any of the advertising claims on any of the reports were in fact not properly categorized or characterized as outreach based on the nature of the ads themselves.

Again, the Government made no effort to claim and did not contend that the advertising costs reflected as outreach were in fact not actual costs and expenses of the particular hospitals involved.

(4) *Reimbursement Effect/Cost Reimbursement Statutory Limitations.* The Government admittedly did not put up any proof to deal with the issue of reimbursement effect with regard to any of the cost reports, apparently on the assumption that the issue did not matter (R. 131, Vol. 9, p. 59). In so doing, however, the Government failed to distinguish between the issue, on one hand, of whether in fact there may or may not have been any reimbursement effect [whether in fact the Government agent was or was not influenced to take action had no bearing upon materiality, if the agency could have been influenced] and, on the other, its affirmative obligation to meet and overcome by proof beyond a reasonable doubt the petitioner's affirmative assertions that as a matter of law the agency could not have been misled, because of the statutory restrictions upon cost reimbursement imposed upon all concerned (intermediaries and providers alike) by the lower-of-cost-or-charges (LCC) limitation and the TEFRA target rate, where applicable.

The petitioner claimed affirmatively that he never sought more reimbursement for any hospital than the TEFRA target rate allowed, when applicable (R. 131, Vol. 8, pp. 63-64) and that the TEFRA target rate applied to the Glade report at issue [count 7], the Woods 1989 cost

report [counts 3 and 14], the Tampa Bay report [count 6, the only report actually authored by the defendant], and that the target rate limited recovery on other cost reports (R. 131, Vol. 8, p. 64). This testimony and evidence was undisputed. In point of fact, the Government's own cost report evidence as to count 4 (Mobile) (see Gov't.'s exhibits in D series, R. 131, Vol. 7, pp. 92-106) established that the TEFRA target rate limitation applied to that report (this is also the hospital where 100% of the advertising/outreach was allowed upon audit).

The Government's witness Harold B. Griffin testified as to the standard about lower-of-costs-and-charges (R. 116, Vol. 5, p. 68), although the Government ignored the application of this standard, even though its own exhibits with respect to the Corpus Christi 1989 report [counts 1 and 9] showed that in fact any cost recovery for royalties and CMCI interest claimed was precluded by that standard.

Don Crossett, the Government witness who was head of reimbursement for 1981 through 1987 for Charter, on cross-examination, not only explained the TEFRA target rate as it applied to count 6 of the indictment (Tampa Bay), but indicated that the listing of royalties and advertising expense by the petitioner on the final cost report was immaterial in terms of reimbursement effect, since the hospital costs were approximately 2 1/2 times the allowable TEFRA target rate amount, which was the only amount claimed (R. 131, Vol. 6, pp. 37-42). Thus, the evidence presented showed affirmatively without dispute that the intermediary could not have been deceived with regard to the cost reports filed as to counts 1 and 9 (Corpus Christi), Tampa Bay (count 6), Mobile (count 4), Woods 1989 (counts 3 and 14), and Charter Glade (count 7).

The language of the indictment (R. 63, Vol. 1, R. Exc. Tab 2) is critical in light of the way in which the Court of Appeals approached this case, and in light of the constitutional issues of Fifth Amendment notice, Sixth Amendment fair trial, and materiality are concerned. Each count of the indictment having to do with false statements expressly alleged that petitioner made or caused to be made false statements claiming Medicare reimbursement for one hospital or another to which Charter was not entitled. There was no allegation in any of the indictment counts that petitioner had violated 18 U.S.C. §1001 by concealing relevant information he had a duty to disclose. As the Court of Appeals itself noted, the mail fraud counts allege fraud through mailing of the false cost reports, and as such petitioner's convictions on those counts rest on the false statement charges. 97 F. 3d 522. At no time at trial did the Government attempt to prove to the jury the existence of any statute or regulation which required affirmative disclosure, so as to justify reliance upon the concealment prong of §1001, and in any event, as stated, never charged petitioner by indictment with violating the criminal statute in such fashion. The Court of Appeals expressly found that the Government had failed to carry its burden of proving (as alleged in the indictment) the non-reimbursability of the claims for CMCI interest and royalty expense, 97 F. 3d 526, 528, although it did not address a similar failure of proof (which is undisputed) as to the outreach/advertising issue. Rather, the Court of Appeals, despite the manner in which the charges were preferred by indictment and the way in which proof was presented by the Government at trial, instead affirmed the convictions on a concealment theory, which was never proven by the Government at trial or charged against petitioner.

The defense had centered strongly, as summarized hereinbefore, upon the fact that the Government could not be misled (i.e., that the cost report claims at issue

were not material) because of the intermediary review process, the mandatory review procedures required of the intermediaries, and particularly the limitations imposed by the lower-of-cost-or-charges limitations and the TEFRA target limit. Nonetheless, without articulating a basis for his findings, Judge Fitzpatrick in accordance with then applicable law in the Eleventh Circuit, and without announcing the degree of proof required or the standard applied for his finding (preponderance, beyond a reasonable doubt, etc.), ruled as a matter of law that the submission of the false claims was material and took the issue away from the jury after so instructing them (R. 131, Vol. 9, p. 69).

The Court of Appeals did review the issue of materiality, which had been raised by the evidence, as hereinbefore described. Because no objection was raised to the non-submission of materiality to the jury, the Court of Appeals treated the issue as one for determination under the "plain error" standard of Federal Rule of Criminal Procedure 52(b) and *United States v. Olano*, 507 U.S. 725, 113 S.Ct. 1770, 123 L. Ed. 2d 508 (1993), determining that the failure to submit the materiality issue to the jury "could not have affected the outcome because there is no reasonable argument that the statements at issue here were not material." 97 F. 3d 529-30.

Such other facts as are necessary to the Court's decision are stated in argument.

IV. ARGUMENT

A. SINCE PETITIONER WAS DEPRIVED OF A JURY DETERMINATION AS TO THE CRITICAL ELEMENT OF MATERIALITY, WHICH WAS NOT SUBMITTED TO THEM, AND HENCE CLEAR ERROR OCCURRED, SUCH ERROR CAN NEVER BE RENDERED "PLAIN" OR HARMLESS, SINCE PETITIONER WAS BY THAT ERROR DEPRIVED OF HIS FIFTH AMENDMENT RIGHT TO DUE PROCESS OF LAW AND HIS SIXTH AMENDMENT RIGHT TO TRIAL BY JURY, AND REVERSAL IS REQUIRED

Although materiality was a critical factual defense developed by petitioner's evidence and argument during trial, the trial court instructed the jury that the false statements were material as a matter of law. Under then settled law of the Eleventh Circuit, petitioner's counsel raised no objection to the Court's determination of materiality. *See United States v. Calhoon*, 97 F. 3d 518, 529 (11th Cir. 1996). The Court did not make any announcement or determination on the record with respect to the burden to which it was holding the Government or the standard (preponderance, beyond a reasonable doubt, etc.) which it found applied to its determination.

Following the trial, this Court decided *United States v. Gaudin*, ___ U.S. ___, 115 S.Ct. 2310, 32 L. Ed. 2d 444 (1995), which held that the element of materiality, being an essential element of the crime, was a matter for the jury, not the Court. The *Gaudin* holding applies retroactively to this appeal. *See Griffith v. Kentucky*, 479 U.S. 314, 328, 107 S.Ct. 708, 716, 93 L. Ed. 2d 649 (1987). Because the defense had not objected to the trial court's determination of the materiality issue, rather than the jury, the Eleventh Circuit on appeal in this case reviewed the failure to submit the materiality issue to the jury under *Gaudin* under the plain error standards of *United States v. Olano*, 507 U.S. 725, 113 S.Ct. 1770, 123 L. Ed. 2d 508 (1993), and Federal Rule of Criminal Procedure 52(b),

rather than considering the matter a "structural" or constitutionally fundamental error as required by *Sullivan v. Louisiana*, 508 U.S. 275, 113 S.Ct. 2078, 124 L. Ed. 2d 182 (1993) and, implicitly, *Gaudin* itself. *See also Rose v. Clark*, 478 U.S. 570, 106 S.Ct. 3101, 92 L. Ed. 2d 460 (1986). The Eleventh Circuit in *Calhoon* determined that a failure to submit the issue of materiality to the jury could not have affected the outcome "because there is no reasonable argument that the statements at issue here were not material." The position taken by the Eleventh Circuit in this case was consistent with its prior decision in *United States v. Kramer*, 73 F. 3d. 1067 (11th Cir. 1966).

The problem with the Eleventh Circuit's approach, and indeed the approach of several other Circuits (*see United States v. Wiles*, 102 F. 3d 1043, 1060-61 n. 12 and 13 (10th Cir. 1996) (en banc), which provides a detailed summary of the conflicting positions on this issue among the Circuits), is that the plain error standard ignores the critical impact under the Fifth and Sixth Amendments to the Constitution of the United States of a failure to submit all elements of a criminal offense to a jury for its determination on guilt or innocence. It also, in the absence of some announced standard by either the trial or appellate court to the contrary, obviates the Government's burden of proving each essential element of the offense beyond a reasonable doubt. Attempting to make a distinction on the grounds that there was a failure of objection to an established and long line of precedent, which authorized the trial court to determine materiality, begs the question. Indeed, as noted by the Ninth Circuit,

> An exception [to the instruction] would not have produced any results in the trial court. Under these circumstances were we to insist that an exception be taken to save the point for appeal, the unhappy result would be that we would encourage defense counsel to burden district courts with repeated assaults on their settled principles out of hope that those principles will be later overturned, or out of fear that

> failure to object might subject counsel to a later charge of incompetency.

United States v. Scott, 425 F. 2d 55, 57-58 (9th Cir. 1970) (en banc). Some errors are so fundamental to the determination of guilt or innocence that a mere "plain error" review simply does not address the criticality of the issue. When there is no reason for a petitioner to believe that there are grounds to assert error, there can be no constitutional waiver amounting to an "intentional relinquishment or abandonment of a known right." *Johnson v. Zerbst*, 304 U.S. 458, 464 (1938).

In *United States v. Wiles, supra*, the Tenth Circuit en banc concluded that a harmless error or a plain error analysis under Federal Rule of Criminal Procedure 52(a) or (b) simply did not address a structural defect in the constitution of the trial mechanism, which defies analysis under Rule 52, because the error renders the trial an unreliable vehicle for the determination of guilt. *Rose v. Clark*, 478 U.S. at 577-78, 106 S.Ct. at ___, 92 L. Ed. 2d 460 (1986). The Ninth Circuit in *United States v. Keys*, 95 F. 3d 874 (9th Cir. 1996) (en banc) took a different view, finding that the *Gaudin* analysis as to materiality was subject to harmless error analysis, but always required reversal.

Simply put, the Circuits are going in all different directions in dealing with this Court's decision in *Gaudin*, and establish that there is a clear conflict among the Circuits as to what standard of review – harmless error, plain error, structural error – should be applied.

This Court recently granted certiorari in the case of *Johnson v. United States*, 117 S.Ct. 451 (1996), a case previously affirmed by the Eleventh Circuit without opinion at 82 F. 3d 429. Counsel for petitioner is advised by counsel for the appellant in *Johnson* that oral argument has recently been held in the case and that a decision from this Court is pending. Since the decision in the instant matter may well be controlled by *Johnson*, petitioner prays that the Court either grant certiorari and stay decision pending a determination of the applicability of the *Johnson* decision to the instant case, or stay ruling on the

present petition pending the outcome of this Court's decision in that matter, provided that certiorari is not independently granted on either of the other two issues urged in this petition.

B. A PERSON CAN NEVER BE CONVICTED OF SUBMITTING FALSE OR FRAUDULENT MEDICARE CLAIMS FOR MONIES ACTUALLY AND PROPERLY EXPENDED, REGARDLESS OF INTENT, WHEN THE GUIDELINES GOVERNING REIMBURSEMENT RELIED UPON BY THE GOVERNMENT TO SHOW FALSITY ARE NON-BINDING AND OF PRESUMPTIVE VALIDITY ONLY, AND SUBJECT TO ADJUSTMENT UNDER A FLUID ADJUDICATORY REVIEW SYSTEM

In its most recent discussion of Medicare reimbursement, this Court expressly recognized and approved the necessarily flexible nature of the reimbursement process. *Shalala v. Guernsey Memorial Hospital*, 514 U. S. ___, 115 S. Ct. 1232, ___, 131 L. Ed. 2d 106, 116-17 (1995). Recognizing that the administrative guidelines set forth in the Provider Review Manual do not have the weight of law (*Id.* at ___, 115 S. Ct. at ___, 131 L. Ed. 2d at 119; *accord*, *Charter Peachford Hospital, Inc. v. Bowen*, 803 F. 2d 1541, 1546-47 (11th Cir. 1986)), the Court indicated that the Secretary relied upon an elaborate adjudicative structure to address particular reimbursement details not covered by enacted regulations, including the right to review by the Provider Reimbursement Review Board, as well as by the Secretary and federal district court when appropriate. The Court went on to recognize that it was appropriate for the Secretary, in the proper exercise of her statutory mandate, to allow reimbursement determinations to evolve through adjudication and decision-making, rather than unilaterally determining all reimbursement issues by enactment of regulations. *Id.* at ___, 115 S. Ct. at ___, 131 L. Ed. 2d at 117.

This Court's interpretation is completely consistent with and reaffirms the Circuit Courts' view of HCFA's Medicare reimbursement process at or about the time the transactions at issue in this case arose. *E.g., Medical Center Hosp. v. Bowen*, 839 F. 2d 1504, 1512-13 (11th Cir. 1988); *Regents of Univ. of Cal. v. Heckler*, 771 F. 2d 1182 (9th Cir. 1985).

> [T]he cost limit methodology enables intermediaries to disallow costs in the first instance without having to engage in a case-specific evaluation of reasonableness. . . . Congress' emphasis that the limits were to be applied on a *presumptive* basis, however, indicates that it intended that the provider retain the right to seek an adjustment of the intermediary's reimbursement determination on the basis that the costs disallowed were in fact reasonable and therefore reimbursable.

Medical Center Hosp. v. Bowen, supra at 1512 (emphasis in original).

If, then, an intermediary's disallowance according to Manual guidelines of claims for costs actually expended (as in this case) has presumptive validity only, by definition submission of claims – even with advance knowledge that they would be disallowed – cannot be false nor can it be illegal. JOHN CALHOON in his representation of the provider hospitals seeking Medicare reimbursement had the absolute right to assert and insist upon an opportunity to prove the reasonableness of the costs alleged, either through negotiation with the intermediary, or through appropriate appeal procedures to the Provider Reimbursement Review Board and even beyond.

The Government's entire case is based upon a legal falsity. It has improperly brought this prosecution and has led the trial and appellate courts into error by convincing the Courts that falsity and materiality existed, where as a matter of law the defendant was making claims he had a right to make. Accordingly, there could

be no violation of 18 U.S.C. §1001, nor could there be fraud under 18 U.S.C. §1341.

The conviction of petitioner accordingly represents a marked departure from the constitutional standards mandated by this Court requiring notice that proscribed conduct is clearly criminal. The vague and fluid standards of 42 U.S.C. §1395x(v)(1)(A) and non-binding Medicare reimbursement guidelines hardly provide the specificity necessary to designate conduct which is criminally prohibited.

"[I]t is well settled that courts are obligated to interpret a statute in a manner which avoids potential constitutional infirmities." *NLRB v. Catholic Bishop of Chicago*, 440 U.S. 490, 500, 99 S.Ct. 1313, 1318, 59 L.Ed. 2d 533 (1979); *United States v. Rumely*, 345 U.S. 41, 45, 73 S.Ct. 543, 545, 97 L.Ed. 770 (1953). The same principle applies equally to administrative regulations. *Trustees of Indiana University v. United States*, 618 F. 2d 736, 740 (Ct. Cl. 1980); *Northwest Hospital, Inc. v. Hospital Service Corp.*, 687 F. 2d 985, 992 (7th Cir. 1982). The court in the *Northwest Hospital* case invalidated an interpretation of a Medicare regulation which on its face purported to disallow provider reimbursement of interest on a related-party loan as being inconsistent with the provider's entitlement under the Medicare statute to be reimbursed for its direct and indirect reasonable costs properly applicable to the care of Medicare patients.

As stated by the United States Supreme Court in *Dunn v. United States*, 442 U.S. 109, 112, 99 S.Ct. 2190, 2197, ___ L.Ed. ___ (1979), "[t]his practice of [resolving questions concerning the impact of a criminal statute in favor of lenity] reflects not merely a convenient maxim of statutory construction. Rather it is rooted in fundamental principles of due process which mandate that no individual be forced to speculate, at peril of indictment, whether his conduct is prohibited. . . . Thus, to insure that a legislature speaks with special clarity when marking the boundaries of criminal conduct, courts must decline to

impose punishment for actions that are not ('plainly and unmistakably') proscribed."

Following this principle, the Supreme Court, in *Adamo Wrecking Co. v. United States*, 434 U.S. 275, 98 S.Ct. 566, ___ L.Ed. ___ (1978), invalidated the imposition of criminal sanctions for supposed violation of a regulation promulgated under the Clean Air Act, when criminal sanctions were imposed for violation of emissions standards, and the regulation purportedly violated was not clearly shown to be one creating an emission standard. *Id.* at 283-85, 98 S.Ct. at 572-73, ___ L.Ed. ___. As stated earlier by Justice Clark, "[B]usinessmen must not be left to guess the meaning of regulations. . . . In the framework of criminal prosecution, unclarity alone is enough to resolve the doubts in favor of defendants." *United States v. Mersky*, 361 U.S. 438, 465, 80 S.Ct. 459, 465, ___ L.Ed. ___ (1960).

In *United States v. Denemark*, the defendant was convicted of violating 18 U.S.C. §1001, but argued on appeal that the concealment and covering up of a material fact must be directed toward performance or failure to perform some act which is required by statute or regulation. The Eleventh Circuit agreed, citing *Lanzetta v. New Jersey*, 306 U.S. 451, 453, 59 S.Ct. 618, 619, ___ L.Ed. ___ (1939), to the effect that "No one may be required at peril of life, liberty, or property to speculate as to the meaning of penal statutes. All are entitled to be informed as to what the State commands or forbids." *See United States v. Denemark*, 779 F. 2d 1559, 1563 (11th Cir. 1989); *United States v. Race*, 632 F. 2d 1114 (4th Cir. 1980) (defendants' conviction for violation of 18 U.S.C. §1001 was reversed because of the Government's failure to carry its burden of negating any reasonable interpretation that would make defendants' statements factually correct (see same standard relied upon in *United States v. Adler*, 623 F. 2d 1287 (11th Cir. 1980)). *See also United States v. West*, 666 F. 2d 16 (2nd Cir. 1981); *United States v. Hajecate*, 683 F. 2d 894 (5th Cir.), *cert. denied*, 461 U.S. 927, 103 S.Ct. 2086 (1982); *United States v. Blumberg*, 258 F. Supp. 885 (D.C. Del.

1966); *United States v. Jakeway*, 783 F. Supp. 590 (M.D. Fla. 1992).

Because of the fluidity within the HFCA reimbursement system and the vagueness of the guidelines, and their non-binding and very general standards, all open to interpretation, petitioner's reliance upon and use of the reimbursement process simply cannot constitutionally subject him to criminal sanctions.

C. WHERE THE GOVERNMENT TOTALLY FAILS TO PROVE AS ALLEGED OBJECTIVE FALSITY – THAT THE MEDICARE CLAIMS AT ISSUE WERE IN FACT NOT REIMBURSABLE – PETITIONER'S CONVICTION CANNOT BE CONSTITUTIONALLY AFFIRMED ON A THEORY OF CONCEALING THAT WHICH MAY OR MAY NOT HAVE BEEN FALSE WHEN NOT SO CHARGED IN THE INDICTMENT

It is respectfully submitted that the Court of Appeals decision in this case unconstitutionally deprived JOHN CALHOON of his right to have the Government prove every essential element of the violations charged, and functionally relieves the Government from proving the necessary elements of the falsity of the statements made (reimbursement claims) and the alleged non-reimbursability of those claims, by finding that Calhoon "concealed" what were otherwise arguably completely legitimate claims. This is neither what the Government alleged by indictment or attempted to prove. As such, Calhoon stands convicted for something he was neither alleged nor proven to have done.

The Court of Appeals ruling in this case is a marked departure from its decisions in *United States v. Lawson*, 809 F. 2d 1514 (11th Cir. 1987), compared with *United States v. Tobon-Builes*, 706 F. 2d 1092 (11th Cir. 1983), and *United States v. Hernando Ospina*, 798 F. 2d 1570 (11th Cir. 1986), and effectively denies JOHN CALHOON his right to due process under the Fifth Amendment, and his right

to a trial by jury under the Sixth Amendment to the Constitution of the United States.

Both *Tobon-Builes* and *Ospina* recognize the requirement that the Government allege and prove a duty to disclose. *Tobon-Builes* holds categorically that §1001 describes two distinct offenses: false or fraudulent statements; or proof of willful nondisclosure by trick, scheme, or device of statements required to be disclosed by statute, regulation, or form.

Appellant was not indicted for concealment (as were Tobon-Builes and Ospina), the Government did not prove concealment as such or a duty to disclose, and the jury was not charged on concealment as a basis for its §1001 findings.

The Eleventh Circuit's decision in this case allows a conviction to stand on a theory neither alleged nor proven, after acknowledging the failure of the Government to prove what it alleged, 97 F. 3d at 526, 528, and blurs the clear distinctions between the different bases for conviction under §1001 and §1341 developed in the cited cases.

V. CONCLUSION

For all the above and foregoing reasons, petitioner prays that this petition for writ of certiorari be granted and that the Court grant such other and further relief as is appropriate under the circumstances.

Dated: March 31, 1997

Respectfully submitted,

JOHN T. STRAUSS

JOHN T. STRAUSS
Attorney for Petitioner
Georgia Bar No. 686900

JOHN T. STRAUSS, P.C.
P. O. Box 1103
Covington, Georgia 30210
(770) 787-5020

APPENDIX

Appendix A: Decision from Court of Appeals..... A-1
Appendix B: Denial of Motion for Rehearing B-1

APPENDIX A

UNITED STATES of America,
Plaintiff-Appellee,

v.

John E. CALHOON,
Defendant-Appellant.

No. 95-8171.

United States Court of Appeals,
Eleventh Circuit.

Oct. 16, 1996.

Hospital owner's employee was convicted in the United States District Court for the Middle District of Florida, CR-92-12-MAC(DF), Duross Fitzpatrick, Chief Judge, of mail fraud and false statement in matter within jurisdiction of department or agency of United States. Employee appealed. The Court of Appeals, Schwarzer, Senior District Judge, sitting by designation, held that: (1) employee concealed material facts when seeking Medicare reimbursement for royalty fees and interest payments and in labeling advertising expenses as "outreach"; (2) sentencing court could find employee responsible for $31,000 in intended losses; (3) refusal to grant adjustment for acceptance of responsibility was not penalty for exercise of Sixth Amendment right to jury trial; (4) deliberate ignorance instruction could be given; and (5) testimony by hospital owner's former senior manager was not hearsay and was admissible.

Affirmed.

Appeal from the United States District Court for the Middle District of Florida [sic].

Before KRAVITCH and BIRCH, Circuit Judges, and SCHWARZER*, Senior District Judge.

SCHWARZER, Senior District Judge:

John E. Calhoon was charged in a 14-count indictment with violation of 18 U.S.C. § 1001 (false statements) and 18 U.S.C. § 1341 (mail fraud). At trial, the government dismissed two counts. The jury acquitted on one count and convicted on the remaining eleven. Each of the eight false statement counts of conviction charged Calhoon with signing or causing to be signed a Medicare cost report claiming amounts he knew not to be reimbursable. The three mail fraud counts of conviction charged him with devising a scheme to defraud with respect to three of the false cost reports by use of the mail. Calhoon appeals from the judgment of conviction. We have jurisdiction under 28 U.S.C. § 1291 and 18 U.S.C. § 3741(a) and affirm.

FACTUAL BACKGROUND

The charges against Calhoon arose out of actions he took while employed by Charter Medical Corporation (CMC), a national hospital chain headquartered in Macon, Georgia and composed of both medical/surgical and psychiatric hospitals. Calhoon was responsible for

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* Honorable William W Schwarzer, Senior U.S. District Judge for the Northern District of California, sitting by designation.

obtaining Medicare reimbursement for a group of the psychiatric hospitals belonging to CMC. To obtain reimbursement, CMC filed cost reports with private insurance companies acting under contract with the Health Care Financing Administration (HCFA), the agency within the Department of Health and Human Services responsible for administering the Medicare program. These private insurance companies act as fiscal intermediaries to review and, as necessary, to audit cost reports to determine the amount of reimbursement to which the provider of Medicare-insured services is entitled. Calhoon chaired one of two sections at CMC responsible for filing cost reports with the intermediaries; in that capacity he supervised a group of accountants who prepared the reports.

To satisfy provider hospitals' cash requirements, the intermediaries paid CMC periodically throughout the fiscal year for estimated Medicare costs. At the end of the fiscal year, CMC filed annual cost reports for each hospital setting out the costs that it actually incurred. Based upon those cost reports, the intermediaries determined the correct amount of Medicare reimbursement for the year and either paid CMC the amount due or billed it for excess interim payments.

Cost reports filed on behalf of a provider hospital include a statement of the total costs expended by the hospital for each category of expense. Some costs included in a cost report are clearly identifiable as either reimbursable or nonreimbursable. Other costs are subject to dispute. In order for the provider hospital to preserve its right to challenge any potential disallowance of an item of cost or part thereof, the provider must include that item within the cost report. The cost report filing

process requires providers to identify accurately both the nature and the amount of the costs claimed, thereby permitting the intermediary to identify and disallow the nonreimbursable costs, while allowing the provider to preserve on appeal its claim for those costs which it deems reimbursable. More specifically, on the settlement page of the cost report, the provider identifies as presumptively nonreimbursable the cost for which it nonetheless seeks reimbursement. This is referred to as filing "under protest." The intermediary then determines which costs are reimbursable based on the regulations enacted by the Secretary of Health and Human Services and a set of policy decision/guidelines called the Provider Reimbursement Manual ("Prov.Reimb.Man.").

Because of the sizeable volume of cost reports submitted to intermediaries, however, the intermediaries give only some cost reports a full audit, including a field visit by the intermediary to the hospital to compare the cost reports with the hospital's internal records. Other cost reports receive only cursory review. When presented with a cost report, the intermediary generally does a preliminary desk audit to determine whether a field audit is appropriate based on the information presented by the provider.

After an intermediary conducts whatever audit it deems appropriate, it issues a notice of program reimbursement to the provider. The provider then has 180 days to negotiate any disputed issue with the intermediary or to file an appeal with an administrative body known as the Provider Reimbursement Review Board.

Calhoon's convictions were based on claims in cost reports filed on behalf of six different CMC hospitals between 1987 and 1989.

DISCUSSION

I. VIOLATION OF SECTIONS 1001 AND 1341

To sustain a conviction for violation of 18 U.S.C. section 1001, the government must prove (1) that a statement was made; (2) that it was false; (3) that it was material; (4) that it was made with specific intent; and (5) that it was within the jurisdiction of an agency of the United States. *See United States v. Lawson*, 809 F.2d 1514, 1517 (11th Cir.1987). To sustain a conviction for mail fraud under 18 U.S.C. section 1341, the government must prove (1) intentional participation in a scheme to defraud a person (including the government) of money or property; and (2) the use of the mails in furtherance of the scheme. *See United States v. Smith*, 934 F.2d 270, 271 (11th Cir.1991). The government charged that Calhoon's submissions by mail of the Medicare claims at issue constituted a scheme to obtain money by virtue of the false documentary claims. Thus, the mail fraud convictions rest on the false statement convictions. Calhoon challenges the validity of these convictions on the grounds that the statements at issue, *i.e.*, the claims for Medicare reimbursement, were neither false nor material.

We review *de novo* whether Calhoon's conduct violated sections 1001 and 1341. *See Lawson*, 809 F.2d at 1517. We also review *de novo* whether there was sufficient evidence to support the convictions; in so doing, we review

the evidence in the light most favorable to the government, accepting all reasonable inferences and credibility choices made in the government's favor, to determine whether a reasonable trier of fact could find that the evidence established guilt beyond a reasonable doubt. *See United States v. Keller*, 916 F.2d 628, 632 (11th Cir.1990), *cert. denied*, 499 U.S. 978, 111 S.Ct. 1628, 113 L.Ed.2d 724 (1991); *United States v. Gafyczk*, 847 F.2d 685, 691-92 (11th Cir.1988).

A. *Falsity*

Falsity under section 1001 can be established by a false representation or by the concealment of a material fact. *See* 18 U.S.C. § 1001 ("Whoever . . . falsifies, conceals or covers up by any trick, scheme, or device a material fact, or makes false, fictitious or fraudulent statements or representations . . . shall be fined not more than $10,000 or imprisoned not more than five years, or both."); *United States v. Tobon-Builes*, 706 F.2d 1092, 1096 (11th Cir.1983) (falsity based on concealment of a material fact). Calhoon's convictions were based on Medicare claims for three separate categories of expenses: (1) royalty fees paid to CMCI, a sister subsidiary, (2) interest paid to CMCI ("CMCI interest"), and (3) advertising costs claimed under the label of "outreach." Regarding the claims for royalty fees and CMCI interest, the government essentially maintains that Calhoon made false representations by claiming reimbursement for costs that were nonreimbursable under the applicable Medicare provisions. Calhoon argues, however, that no provisions made these costs clearly nonreimbursable and claiming

them as reimbursable therefore cannot be a false representation and the basis of criminal liability. Regarding the advertising costs, the government maintains that by claiming reimbursement for advertising costs under the term "outreach," Calhoon concealed the true nature of the costs as advertising, some of which is reimbursable and some of which is not. Calhoon argues, however, that "outreach" was a factually accurate description of the costs and a term accepted by the industry to describe certain advertising. Thus, he argues, claiming these costs as outreach cannot constitute falsity. For the reasons discussed below we conclude that the claims for all three types of costs were false for purposes of section 1001.

1. *The Intercompany Charges: Royalty Fees and CMCI Interest*

Linton Newlin, the person responsible for tax planning and related matters for CMC, testified that he created a Nevada corporation, CMCI, as a subsidiary of CMC in order to gain various tax advantages. CMC transferred ownership of the Charter name to CMCI, and individual hospitals then paid a one-time royalty fee to CMCI to use the Charter name. Because Charter is a national corporation, the hospitals benefitted from the use of the name and because CMCI was incorporated in Nevada where corporations are not subject to state income tax, CMCI increased its profits through tax savings.

Besides licensing the Charter name, CMCI obtained funds from the parent company and loaned the money to

the CMC hospitals, which, in turn, paid back tne principal with interest to CMCI. The hospitals took a tax deduction for interest payments to CMCI, and CMCI paid no state corporate income tax on the interest income. Newlin testified that actual money was paid by the hospitals to CMCI on account of both the royalty fees and the CMCI interest.

Calhoon freely admitted both in an investigative interview and at trial that he believed at all times relevant that the royalty fees and CMCI interest were presumptively nonreimbursable under the applicable Medicare provisions. *See* R.A. Vol. 8, p. 134; R.A. Vol. 9, pp. 103-04. John Banfield (one of Calhoon's former subordinates) testified, and the jury accepted, that Calhoon instructed Banfield to claim for reimbursement the royalty fees and interest paid to CMCI but to recognize the probable disallowance of the claims by listing the amounts on reserve cost reports. R.A. Vol. 7, p. 161; R.A. Vol. 8, pp. 12-13; R.A. Vol. 9, p. 110.

a. *Royalty Fees*

The government contends that the royalty fees claimed were nonreimbursable because: (1) they were unrelated to patient care, *see* 42 U.S.C. § 1395x(v)(1)(A); 42 C.F.R. § 413.9, and (2) they were not an actual expense, *see* 42 U.S.C. § 1395x(v)(1)(A); 42 C.F.R. § 413.17. It argues that the royalty fee amounted to a franchise fee paid to a related party for the use of the Charter name. As such, CMC money was simply being moved from one pocket to another, making the fee nonreimbursable because it was not an actual expense. *See* 42 U.S.C. § 1395x(v)(1)(A); 42

C.F.R. § 413.17. The government also argues that providers must accurately identify the nature and amount of each cost claimed. The cost reports here did not disclose that the royalty fees were paid to a related company, CMCI.

Calhoon challenges his convictions based on the claims for royalty fees on the grounds that there are no statutes or regulations clearly prohibiting reimbursement of the royalty fees, and that the former policy guideline on reimbursement of royalty fees was repealed in 1982 and superseded by more general guidelines that arguably permit reimbursement. *See* Prov.Reimb.Man., Part 1 § 2133, *repealed by* Transmittal No. 263 (Mar. 1982); Prov.Reimb.Man., Part I § 2135. More specifically, Calhoon argues that the statutory and regulatory standards governing whether a royalty fee is reimbursable require only that the costs be "actually incurred" and reasonably related to patient care. *See* 42 U.S.C. § 1395x(v)(1)(A) (reimbursable costs include "reasonable cost of any services shall be actually incurred," except "incurred costs found to be unnecessary in the efficient delivery of needed health services"); 42 C.F.R. § 413.9 (reimbursements must be based on costs reasonably related to patient care). Calhoon contends that the royalty fees at issue were costs actually incurred because CMCI actually billed the hospitals and the hospitals paid the royalty fees to CMCI. As to whether the costs were reasonably related to patient care, Calhoon argues that the issue is open to debate and that the government failed to produce any evidence showing that the royalty fees were not related to patient care. Thus, Calhoon argues, his convictions cannot be upheld because the government failed to sustain

its burden of negating any reasonable interpretation that would make the royalty fees reimbursable and thereby render the statements in the cost reports factually correct. *See, e.g., United States v. Race,* 632 F.2d 1114, 1119-21 (4th Cir.1980) (government failed to satisfy its burden of proving falsity where billings were authorized under a reasonable interpretation of the terms of the authorizing contract); *United States v. Anderson,* 579 F.2d 455, 459-60 (8th Cir.), *cert. denied,* 439 U.S. 980, 99 S.Ct. 567, 58 L.Ed.2d 651 (1978). Moreover, Calhoon argues, because there is no definite legal standard making royalty fees nonreimbursable, his convictions are unconstitutional. *See Dunn v. United States,* 442 U.S. 100, 112, 99 S.Ct. 2190, 2197, 60 L.Ed.2d 743 (1979) ("[F]undamental principles of due process . . . mandate that no individual be forced to speculate, at the peril of indictment, whether his conduct is prohibited. . . . Thus, . . . courts must decline to impose punishment for actions that are not 'plainly and unmistakably' proscribed.").

(i) *Reimbursability*

We reject Calhoon's contention that there is no provision making the royalty fees paid to CMCI clearly nonreimbursable. Calhoon's arguments focus on whether any provision made the royalty fees clearly nonreimbursable by virtue of their nature as royalty fees. The critical fact is, however, that these royalty fees were paid to CMCI, a company related to the hospitals by common ownership. CMC, the parent company, owned both the hospitals that were paying the royalty fees for use of the Charter name

and CMCI, the Nevada subsidiary that owned the Charter name and collected the royalty fees. Therefore, regardless of whether certain royalty fees are generally reimbursable, whether the royalty fees here were reimbursable is governed by 42 C.F.R. § 413.17 which applies to expenses paid to related organizations.[1] That regulation provides in relevant part:

> (a) *Principle.* Except as provided in paragraph (d) of this section, costs applicable to services, facilities, and supplies *furnished to the provider by organizations related to the provider by common ownership or control* are included in the allowable cost of the organization *at the cost to the related organization.* However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.
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> * * *
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> (c) *Application.* . . . (2) If the provider obtains items of services, facilities, or supplies from an organization, even though it is a separate legal entity, and the organization is owned or controlled by the owner(s) of the provider, in effect the items are obtained from itself. An example would be a corporation building a hospital or a

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[1] Calhoon challenges treatment of the hospitals and CMCI as "related organizations" under this regulation. But the regulation clearly provides that organizations are "related" through common ownership, which "exists if an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider." *See* 42 C.F.R. § 413.17(b)(2). Being commonly owned by CMC, the provider hospitals and CMCI are clearly related organizations within the meaning of the regulation.

> nursing home and then leasing it to another corporation controlled by the owner. *Therefore, reimbursable cost should include the costs for these items at the cost to the supplying organization.* However, if the price in the open market for comparable services, facilities, or supplies is lower than the cost to the supplier, the allowable cost to the provider may not exceed the market price.

42 C.F.R. § 413.17.

Under this regulation, expenses paid by the hospitals to CMCI – including the royalty fees at issue here – are reimbursable only "at the cost to [CMCI], the supplying organization." *See* 42 C.F.R. § 413.17(c). At trial, the government's expert, Bessie Wheeler, explained that royalty fees paid to a related company solely for the use of a name would not be an actual expense for the company and, therefore, would not be reimbursable by Medicare. R.A. Vol. 6, p. 106. She explained that, for the fee to be reimbursable, it would have to be paid in exchange for an actual service that the related company provided at a real cost. *Id.* The reimbursable costs related to the Charter name may have been actual costs of acquiring and maintaining the Charter trademark. Whether the royalty fee paid is reimbursable depends in part on whether it reflected actual cost to CMCI of the acquisition or maintenance of the Charter name. *See* 42 C.F.R. § 413.17. If the royalty fees did not directly reflect such an actual cost, they would not have been reimbursable. *See* 42 C.F.R. § 413.17; *cf.* Prov.Reimb.Man., Part 1, § 1011.5 (Govt.Supp.Br., Ex. 7, p. 20) (policy guideline illustrating the application of § 413.17 in the context of a rental expense: where provider leases a facility from a related

organization, costs of ownership of the facility are the allowable costs, not the rent paid to the lessor by the provider). The government, having apparently offered no evidence on this issue, failed to sustain its burden to prove the claim false by virtue of the nonreimbursable nature of the interest.

(ii) *Concealment of a Material Fact*

By concealing that the royalty fees were paid to a related company, however, Calhoon made the claim for reimbursement false. As stated above, falsity under section 1001 includes concealment of a material fact. *See Tobon-Builes*, 706 F.2d at 1096. Falsity through concealment exists where disclosure of the concealed information is required by a statute, government regulation, or form. *See id.* at 1096; *United States v. Hernando Ospina*, 798 F.2d 1570, 1578 (11th Cir.1986). 42 C.F.R. § 413.20(d) states that:

> (1) The provider must furnish such information to the intermediary as may be necessary to –
>
> (I) Assure proper payment by the program, *including the extent to which there is any common ownership or control (as described in § 413.17(b)(2) and (3)) between providers or other organizations*, and as may be needed to identify the parties responsible for submitting program cost reports;. . . .

Moreover, the cost report forms specifically ask the provider the following questions:

A. ARE THERE ANY COSTS INCLUDED ON WORKSHEET A [on which the royalty fees were claimed] WHICH RESULTED FROM TRANSACTIONS WITH RELATED ORGANIZATIONS AS DEFINED IN HCFA PUB 15-I, CHAPTER 10?

B. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS:

C. INTERRELATIONSHIP OF PROVIDER TO RELATED ORGANIZATION(S):

The cost report form then specifically notifies the provider that:

> THE SECRETARY, BY VIRTUE OF AUTHORITY GRANTED UNDER SECTION 1814(B)(1) OF THE SOCIAL SECURITY ACT, REQUIRES THE PROVIDER TO FURNISH THE INFORMATION REQUESTED ON PART C. . . .
>
> THE INFORMATION WILL BE USED BY THE HEALTH CARE FINANCING ADMINISTRATION AND ITS INTERMEDIARIES IN DETERMINING THAT THE COSTS APPLICABLE TO SERVICES, FACILITIES, AND SUPPLIES FURNISHED BY ORGANIZATIONS RELATED TO THE PROVIDER BY COMMON OWNERSHIP OR CONTROL, REPRESENT REASONABLE COSTS AS DETERMINED UNDER SECTION 1861 OF THE SOCIAL SECURITY ACT.

The relevant cost reports failed to disclose that CMCI was a related organization and was receiving the royalty fees claimed for reimbursement. This fact, as discussed above, is critical to the determination whether the royalty fees

could be reimbursable. Its concealment constitutes falsity for purposes of section 1001.

b. *CMCI Interest*

The government contends that the CMCI interest payments were nonreimbursable because they were expenses paid to a related company. *See* 42 C.F.R. § 413.17 and discussion *supra* pp. 525-26. The government argues that the interest did not represent actual costs incurred by CMCI, as required by 42 C.F.R. § 413.17. The payment of interest, the government argues, was merely movement of money from one pocket of CMC, the parent corporation, to another. Calhoon argues, however, that the government at no time attempted to show that the interest expense did not represent an actual cost and, therefore, did not bear its burden of proving the falsity of the statement.

Don Crosset, former head of Charter's Medicare reimbursement division from 1981 through 1987, testified that the hospitals were taking out loans for new construction. *See* R.A. Vol. 7 p. 58. The actual cash ultimately loaned to the hospitals "was being generated" by CMC, the parent corporation. *Id.* CMC then "funded out [that cash] to the Nevada company," CMCI, and CMCI "in turn, loaned [the money] to the hospitals." *Id.* Crosset testified that, as a result of these transactions, there was a reimbursable cost to CMC, the parent company. The company policy was for CMC to account for that cost in claims for the home office expenses. In order to avoid

duplicating costs, CMC had an internal policy that individual hospitals should not claim the CMCI interest as reimbursable.[2]

As discussed above, where a provider obtains services, facilities, or supplies from a related organization, the reimbursable cost includes only *"the costs for these items at the cost to the supplying organization."* 42 C.F.R. § 413.17. In this case, the supplying organization obtained the money loaned to the hospital from yet another related organization, the parent company. *See* 42 C.F.R. § 413.17(b)(1) ("Related to the provider means that the provider to a significant extent is associated or affiliated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies."); 42 C.F.R. § 413.17(b)(3) ("Control exists if an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution."). Whether the interest paid by the hospital to CMCI is reimbursable depends on whether it reflected the actual cost to CMC, the related organization that was ultimately the source of the loan. *See* 42 C.F.R. § 413.17. If the interest claimed was actually the amount of interest CMC was paying an outside lender for the money or the exact income stream foregone by CMC when it chose to lend the money to a subsidiary rather than to invest it outside of the enterprise, the CMCI interest may have been reimbursable. *See* 42 C.F.R. § 413.17; R.A.Vol. 6, p. 111 (testimony of Wheeler, the

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[2] The government does not contend that the amounts claimed are not reimbursable because the claims are duplicative.

government's expert, that whether the CMCI interest was reimbursable under the regulations pertaining to related company transactions depended on where the related organization obtained the money); *cf.* Prov.Reimb.Man., Part 1, § 1011.5 (described *supra* p. 526). The government having offered no evidence about the source of the money obtained by CMC, the cost to CMC to obtain it, or the aggregate cost of CMC's loaning it to CMCI and of CMCI's loaning it to the hospital, failed to sustain its burden of proving that the interest payment was non-reimbursable.

Nonetheless, as with the royalty fees, the cost reports the government introduced demonstrate that Calhoon concealed that the CMCI interest was an expense paid to a related organization. As discussed above, this fact was critical to the determination of whether it could be reimbursable. Its concealment constitutes falsity for purposes of section 1001. *See supra* p. 524.

2. *Advertising Expense Claimed as "Outreach"*

Four of Calhoon's section 1001 convictions relate to claims he made for reimbursement of advertising costs. Calhoon filed cost reports in which he claimed various types of advertising expenses under the label "outreach." In addition, he created a second set of books – new general ledgers – which collapsed into one account labelled "outreach" advertising accounts that appeared separately in other ledgers. The government maintains that Calhoon intentionally disguised advertising costs as outreach in order to mislead the intermediaries and to obstruct their audits. The government essentially argued

falsity under section 1001 based on concealment of a material fact.

Calhoon, on the other hand, contends that the term "outreach" accurately describes the advertising and that the term is recognized in the industry. He therefore argues that claiming reimbursement for advertising costs under that label could not be false.

42 C.F.R. § 413.20(d) states that "[t]he provider must furnish such information to the intermediary as may be necessary to . . . [a]ssure proper payment by the program. . . . " Under the guidelines in the Manual, certain advertising costs are reimbursable and others are not. *See* Prov.Reimb.Man. § 2136. The Manual provides that advertising costs are generally reimbursable if reasonably related to patient care and primarily designed to advise the public of the services available through the hospital and to present a good public image, but not if designed to increase patient census. *See* Prov.Reimb.Man. § 2136.1. That certain advertising costs are presumptively non-reimbursable obligates a provider seeking reimbursement to identify the costs as "advertising" and to reveal the nature of the advertising. In addition, 42 C.F.R. § 413.20(a) requires providers to maintain financial records for proper determination of reimbursable costs using "[s]tandardized definitions . . . that are widely accepted in the hospital and related fields. . . . " Thus, Calhoon had a legal duty to disclose both in the cost reports and in the general ledgers that the costs claimed were in fact "advertising" costs. Instead, he chose to call the costs "outreach," thereby concealing the potentially nonreimbursable nature of the costs.

Wheeler, the government's expert witness, testified that in 22 years' experience with Blue Cross/Blue Shield of South Carolina, she had never seen the term "outreach" used in Medicare cost reporting; nor had she ever heard "outreach" as a synonym for advertising. R.A.Vol. 6, p. 101. Moreover, Calhoon, a former fiscal intermediary, knew that this term would conceal the nature of the costs and nonetheless chose to use the label specifically for that reason. As one of his subordinates testified, Calhoon admitted that the "outreach" account was created so that there would be no red flag alerting Medicare auditors to the nonreimbursable advertising expenses. *See* R.A.Vol. 8, p. 116. Calhoon similarly told another subordinate that "if just one intermediary misses an adjustment because it is called outreach, these general ledgers have served their purpose." *See* R.A.Vol. 8, p. 205. The evidence was sufficient to lead a reasonable jury to conclude beyond a reasonable doubt that, by using the term outreach, Calhoon concealed the true nature of the advertising costs claimed for reimbursement, thus establishing falsity under section 1001.

3. *Medicare as a Flexible, Discretionary System*

Calhoon also makes a more general argument that claiming costs for Medicare reimbursement can never give rise to criminal liability so long as the costs claimed were actually incurred. He justifies this contention on the grounds (1) that because Medicare is a flexible and discretionary reimbursement system in which the administrative guidelines in the Provider Reimbursement Manual

give only presumptive guidance, (2) that the intermediaries' decisions are only presumptive, and (3) that the denial of reimbursement can be challenged on appeal. *See Shalala v. Guernsey Memorial Hospital*, 514 U.S. ___, ___-___, ___, 115 S.Ct. 1232, 1236-37, 1238-39, 131 L.Ed. 106, 116-17, 119 (1995) (intermediary's disallowance based on Manual guidelines is presumptive only, and subject to appeal); *Medical Center Hosp. v. Bowen*, 839 F.2d 1504, 1512-13 (11th Cir.1988) (same). Calhoon argues that under this system he is entitled to claim reimbursement for costs that may be nonreimbursable and, therefore, that doing so can never be a false statement.

While it is true that a provider may submit claims for costs it knows to be presumptively nonreimbursable, it must do so openly and honestly, describing them accurately while challenging the presumption and seeking reimbursement. Nothing less is required if the Medicare reimbursement system is not to be turned into a cat and mouse game in which clever providers could, with impunity, practice fraud on the government. As Wheeler, the government's expert witness testified, if a provider disagrees with the intermediary, with the intermediary's past decisions, with the instructions or guidelines in the Provider Reimbursement Manual, or with the regulations, the provider must file the cost report "under protest." *See supra* p. 523. Calhoon testified that he understood this system of filing presumptively nonreimbursable costs and that he, in fact, used this system for other types of costs claimed in the very cost reports at issue here. Yet he failed to follow this procedure for the royalty fees, the CMCI interest, or the advertising costs.

In sum, Calhoon's argument misses the crux of his offense: the filing of reports intended and designed to deceive and mislead the auditors for the purpose of obtaining reimbursement of costs Calhoon knew to be at least presumptively, if not clearly, nonreimbursable. Available time and resources do not permit audit of more than a fraction of the cost reports filed. Calhoon's filing of reports claiming costs that were at least presumptively nonreimbursable while concealing or disguising their true nature was a deliberate gamble on the odds that they would not be questioned.

The evidence amply sustains the findings of falsity.

B. *Materiality*

The trial court, without objection, instructed the jury that the false statements were material as a matter of law. Following the trial, the Supreme Court decided *United States v. Gaudin*, ___ U.S. ___, 115 S.Ct. 2310, 132 L.Ed.2d 444 (1995) holding that materiality is a jury issue. The *Gaudin* holding applies retroactively to this appeal. *See Griffith v. Kentucky*, 479 U.S. 314, 328, 107 S.Ct. 708, 716, 93 L.Ed.2d 649 (1987).

We review assertions of error not objected to at trial for plain error. *See* Fed.R.Crim.P. 52(b); *United States v. Olano*, 507 U.S. 725, 732-34, 113 S.Ct. 1770, 1776-78, 123 L.Ed.2d 508 (1993). This is true even where, as here, error arose only by virtue of a later Supreme Court decision. *See United States v. Kramer*, 73 F.3d 1067, 1074 (11th Cir.1996). Under plain error review, reversal for unobjected-to error is permitted, though not required, where the error is both (1) plain and (2) affects substantial

rights. *Olano*, 507 U.S. at 732-36, 113 S.Ct. at 1776-79; *Kramer*, 73 F.3d at 1074. The failure to submit the question of materiality to the jury is plain error. *Kramer*, 73 F.3d at 1074. Therefore, we need only address the question whether Calhoon's substantial rights were affected, *i.e.*, whether the failure to submit the issue of materiality to the jury affected the outcome of his trial. *See id.* at 1075. We conclude that it could not have affected the outcome because there is no reasonable argument that the statements at issue here were not material.

"To satisfy the element of materiality, it is enough if the statements had a 'natural tendency to influence, or be capable of affecting or influencing a government function.' " *United States v. Diaz*, 690 F.2d 1352, 1357 (11th Cir.1982) (quoting *United States v. Markham*, 537 F.2d 187, 196 (5th Cir.1976), *cert. denied*, 429 U.S. 1041, 97 S.Ct. 739, 50 L.Ed.2d 752 (1977)). We have explained that:

> The Government does not have to show actual reliance on the false statements. A statement can be material even if it is ignored or never read by the agency receiving the misstatement. False statements must simply have the capacity to impair or pervert the functioning of a government agency.

Diaz, 690 F.2d at 1357 (citing *United States v. Lichenstein*, 610 F.2d 1272, 1278 (5th Cir.), *cert. denied sub nom. Bella v. United States*, 447 U.S. 907, 100 S.Ct. 2991, 64 L.Ed.2d 856 (1980)).

Calhoon argues that whether the costs he claimed were reimbursable was debatable and that he therefore had the right to claim them on the cost report. Under the regulatory review process, the intermediary conducts an

independent investigation and determines the reimbursability of the costs. If the intermediary determines the costs are nonreimbursable, the provider is denied payment. Essentially, Calhoon argues that because there is an intermediate step – the audit – his claims did not have the capacity to influence the government. But this ignores that the intermediaries necessarily rely on the information provided in the cost report to make their reimbursability determinations, and it ignores the reality of limited audit capability. *See* R.A.Vol. 6, pp. 70-71. The cost reports were sufficient to persuade the intermediary to authorize reimbursement without further investigation. They, therefore, had the capacity " 'to impair or pervert the functioning of a government agency' " by misleading the intermediaries. *See Diaz*, 690 F.2d at 1357 (citing *Lichenstein*, 610 F.2d at 1278).

Moreover, it makes no difference that the initial review for reimbursement is done by the intermediary as opposed to the government agency itself. The intermediaries are acting under contract with the Department of Health and Human Services, which relies, at least in part, on the intermediaries' determination as to reimbursability of the costs.

II. SENTENCING ISSUES

A. *Guideline Computation*

Calhoon argues that the district court erred in determining that he is responsible for $31,000 in intended losses pursuant to U.S.S.G. § 2F1.1(b)(1). He contends that only actual loss is relevant and that the Medicare program sustained none.

Section 2F1.1(b)(1) of the United States Sentencing Guidelines requires that the offense levels be adjusted upward based on the loss attributable to the defendant. Loss "need not be determined with precision. The court need only make a reasonable estimate of the loss, given the available information." U.S.S.G. § 2B1.1, comment. (n. 3) (1988); *see* U.S.S.G. § 2F1.1, comment. (n. 7) (1988) (referring to § 2B1.1). This court reviews district court loss calculations for clear error. *United States v. Menichino*, 989 F.2d 438, 440 (11th Cir.1993).

At sentencing, the government argued that Calhoon should be held responsible for attempting to defraud the Medicare program of $1,596,365. R.A.Vol. 11, p. 22. The government arrived at this figure through a complex series of calculations based on the Medicare regulations. Calhoon argued that the government sustained no actual loss and that no loss was intended. R.A.Vol. 11, pp. 189-90. He admitted, however, that suspect entries on the cost reports had a potential "reimbursement effect" of approximately $31,000. R.A.Vol. 11, pp. 69, 139. Both parties presented witnesses and other evidence in support of their contentions at the day-long sentencing hearing. The sentencing court, noting that it had "as many questions at the end of the day as [it] had at the beginning," rejected the government's figure and imposed sentence based on the $31,000 figure suggested by Calhoon. R.A.Vol. 11, p. 193. We find no error.

Calhoon's assertion that he should be held responsible only for actual loss is without merit. The Sentencing Guidelines recognize that attempted or intended loss is a valid measure of culpability. U.S.S.G. § 2F1.1, comment. (n. 7) (1988); *United States v. Shriver*, 967 F.2d 572, 574

(11th Cir.1992). Calhoon's reliance on *United States v. Wilson*, 993 F.2d 214 (11th Cir.1993), is misplaced. In *Wilson*, this court held that incidental or consequential loss is not relevant for purposes of sentencing. *Id.* at 217. *Wilson* did not hold that actual loss need always be calculated; nor did it hold that *intended* loss is an inappropriate measure of loss. At sentencing, Calhoon admitted that, if the disputed claims had not been intercepted by an auditor, the claims could have netted CMC an additional $31,000 in reimbursements. That admission is sufficient to establish that, in making the false statements, he intended that the government suffer a loss in that amount. *Cf. Shriver*, 967 F.2d at 574.

B. *Acceptance of Responsibility*

Calhoon argues that the district court's refusal to grant an adjustment for acceptance of responsibility amounted to a penalty for exercise of his Sixth Amendment right to trial by jury. The government argues that the district court's decision was not clearly erroneous and that Calhoon's constitutional rights were not infringed.

A defendant bears the burden of showing that he is entitled to an acceptance of responsibility reduction. *United States v. Anderson*, 23 F.3d 368 (11th Cir.1994). Even a defendant who pleads guilty is not entitled to a sentencing reduction for acceptance of responsibility as a matter of right. *United States v. Anderson*, 23 F.3d at 369; *see United States v. Cruz*, 946 F.2d 122, 126 (11th Cir.1991). "[A]cceptance of responsibility" is a "multi-faceted concept," which considers

> among other things, the offender's recognition of the wrongfulness of his conduct, his remorse for the harmful consequences of that conduct, and his willingness to turn away from that conduct in the future.

United States v. Scroggins, 880 F.2d 1204, 1215 (11th Cir.1989), *cert. denied*, 494 U.S. 1083, 110 S.Ct. 1816, 108 L.Ed.2d 946 (1990). This court reviews district court findings regarding acceptance of responsibility for clear error. *United States v. Carroll*, 6 F.3d 735, 739 (11th Cir.1993) *cert. denied sub nom. Jessee v. United States*, 510 U.S. 1183, 114 S.Ct. 1234, 127 L.Ed.2d 577 (1994).

At sentencing, Calhoon argued that he should be given credit for acceptance of responsibility because he had cooperated fully with authorities and had not denied any of the alleged overt acts. R.A.Vol. 11, pp. 4-6; PSI Addendum. He also argued that the denial of an adjustment would infringe his right to trial by jury. *Id.* The district court determined that Calhoon was not entitled to a reduction for acceptance of responsibility because he had not accepted responsibility at all. The court expressed its unease about awarding Calhoon credit for accepting responsibility, pointing out that the guidelines anticipate remorse and acknowledgment of wrongdoing. R.A.Vol. 11, p. 170. The court offered Calhoon an opportunity to accept responsibility before the sentence was imposed, but Calhoon declined to do so. Because, at sentencing, Calhoon maintained that the acts underlying his conviction were not improper, the court did not err in denying adjustment for acceptance of responsibility.

Nor does such a denial violate Calhoon's constitutional rights. As this court has previously recognized, a

reward in the form of an adjustment for acceptance of responsibility for those who plead guilty "does not equate with punishing one who does not follow such a course." *United States v. Castillo-Valencia*, 917 F.2d 494, 501 (11th Cir.1990), *cert. denied sub nom. Pulido-Gomez v. United States*, 499 U.S. 925, 111 S.Ct. 3120, 113 L.Ed.2d 253 (1991); *see also Carroll*, 6 F.3d at 739-40) (Fifth Amendment right not to testify not infringed by failure to grant adjustment for acceptance of responsibility).

III. OTHER ISSUES

Calhoon raises a number of other issues, all of which are meritless. We address each briefly below.

A. *Count Four Conviction: 100 Percent of Advertising Costs Were Reimbursed*

Calhoon argues that the conviction on count four must be reversed because the outreach costs claimed were actually reimbursed. But the fact of reimbursement affects neither the falsity nor the materiality of the statement in the cost report claiming advertising costs as outreach.

"A document is false when made or used, if it is untrue and is then known to be untrue by the person making or using it." *Eleventh Circuit Pattern Jury Instructions, Criminal Cases*, Offense Instruction 29 (1985); *see United States v. Anderson*, 579 F.2d 455 (8th Cir.1987). What made the claim for outreach false was that it concealed a material fact – the nature of the costs as advertising costs, which may or may not have been reimbursable.

Calhoon, therefore, made a false statement the moment "outreach" was claimed in the cost report and supported by a general ledger reflecting the same. That the costs were ultimately reimbursed does not make the statement true when made.

As to materiality, section 1001 does not require proof that the statement actually misled the government; the false statement need only "have the capacity to impair or pervert the functioning of a government agency." *Diaz*, 690 F.2d at 1357 (citing *Lichenstein*, 610 F.2d at 1278).

B. *TEFRA and LCC Limitations*

Two types of limitations set a ceiling on Medicare reimbursement. One is the "LCC" limitation: A provider may be reimbursed only for the lower of either actual costs or the charges for the services. The other was imposed by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Under TEFRA, a target amount is determined according to a hospital's cost reporting "base" period, usually the first 12-month reporting period of its history. The target amount is set by taking the hospital's base year, determining the cost per Medicare case, and capping future claims based on the base cost. R.A.Vol. 7, p. 37. The provider generally is not reimbursed for costs exceeding the TEFRA target amount.

Calhoon argues that the TEFRA target rates applied to the cost reports relevant to all counts other than 2, 12, and 13. He points out that, although he did not self-disallow the royalty fees, CMCI interest, or advertising costs on the statement of total costs made in the cost reports, the total allowable costs without those disputed

claims exceeded the TEFRA target amount. Because of the TEFRA cap, Calhoon argues, the government could not have been misled and his statements were, therefore, immaterial. The government responds that the TEFRA limitation could only have affected counts 6, 7, and 14 and that the TEFRA ceiling can be protested so as to permit increased reimbursement.

So far as we can tell from the record, the TEFRA limitation did not specifically bar reimbursement for any of the claimed nonreimbursable costs; all the cost reports are therefore material. In any event, the existence of the ceiling does not exculpate Calhoon from having made false reports.

C. *Count Five: Calhoon Not "Official" Supervisor*

Calhoon also argues that the conviction on count 5 must be reversed because, at the time this report was filed, he had not yet become reimbursement manager, and therefore, he could not have been responsible for the relevant cost report or have "caused" it to be filed. However, the evidence shows that Parker, the person who submitted the report, was "instructed and advised" by Calhoon and that he considered Calhoon his supervisor. That evidence is sufficient to establish that Calhoon "caused" the falsity as alleged in the indictment.

D. *Deliberate Ignorance Instruction*

Calhoon argues that the "deliberate ignorance" charge was unsupported by the evidence and, therefore, should not have been given to the jury. In determining

whether sufficient evidence supported a jury charge, we review the evidence in the light most favorable to the government. *Glasser v. United States*, 315 U.S. 60, 80, 62 S.Ct. 457, 469-70, 86 L.Ed. 680 (1942).

Calhoon testified at trial that he knew royalty fees were not reimbursable but that he simply had not noticed they were included in a cost report because of his role as a hands-off manager. On this evidence, the jury could properly be instructed that he deliberately avoided knowledge of the specifics of reports. *See United States v. Langford*, 946 F.2d 798, 801-02 (11th Cir.1991), *cert. denied*, 503 U.S. 960, 112 S.Ct. 1562, 118 L.Ed.2d 208 (1992). Moreover, the evidence shows that Calhoon actually instructed his subordinates to claim the nonreimbursable costs. In view of the evidence of his direct involvement, it is difficult to see how the instruction could have been prejudicial.

E. *Admission of Opinion Testimony on Outreach/ Advertising*

William E. Hoffman, Jr., former Senior Manager and Director of Appeals at CMC, testified that he had told Calhoon that he did not think that it was proper to collapse all advertising accounts into a single account called "outreach" both because not all advertising was outreach and because collapsing the advertising into a single account did not specifically identify the reimbursable outreach costs. Hoffman testified that Calhoon disagreed. They therefore discussed the matter with Richard Shackelford, an attorney who handled CMC's appellate matters when outside counsel was required. Hoffman

asked Shackelford his opinion as to whether it was appropriate to file the collapsed ledgers. At trial, Calhoon's counsel objected to Hoffman's testifying about Shackelford's answer on the ground that it was hearsay. After hearing argument from both parties on the matter, the district court overruled the objection, permitting Hoffman to testify that Shackelford said that they should absolutely not be filing the collapsed general ledgers. Calhoon challenges the admission of Shackelford's statements on the grounds that it was hearsay and irrelevant and that any relevance it did have was outweighed by danger of unfair prejudice. *See* Fed.R.Evid. 402, 403, 801, 802.

Calhoon cites *United States v. Race*, 632 F.2d 1114 (4th Cir.1980) in support of his argument. In *Race*, the falsity of the statements that served as the basis for a section 1001 conviction depended upon the interpretation of terms of a contract. The court held that expert testimony on the meaning of the contract terms was superfluous and improper. *Race*, 632 F.2d at 1119-20.

Calhoon apparently cites *Race* for the proposition that the testimony here was erroneously admitted because it constituted expert testimony on the meaning of the Medicare regulations in relation to whether claiming the advertising costs as "outreach" was unlawful. However, the government offered Hoffman's testimony about Shackelford's statements not for the truth of Shackelford's statements, but to prove that Calhoon was on notice that there was reason to question the propriety of his actions. Therefore, the testimony was not hearsay and was relevant to whether Calhoon had knowingly filed false claims. *See* Fed.R.Evid. 801(c); *United States v. Gold*,

743 F.2d 800, 817-18 (11th Cir.1984), *cert. denied*, 469 U.S. 1217, 105 S.Ct. 1196, 84 L.Ed.2d 341 (1985) (where former employees testified that they had put their superiors on notice that there was reason to question whether the company's billing practices were in compliance with the law, court held the testimony relevant because it established that the conspirators had reason to know that their activities were illegal).

On whether the probative value was outweighed by an unfair prejudice, this court defers to the discretion of the trial court. *United States v. Elkins*, 885 F.2d 775, 784 (11th Cir.1989), *cert. denied*, 494 U.S. 1005, 110 S.Ct. 1300, 108 L.Ed.2d 477 (1990). We will reverse the trial court's decision to admit the testimony only if it were clearly an abuse of discretion. We find none here. The trial court instructed the jury regarding the limited purpose for which the testimony was offered. Moreover, in light of our conclusion that collapsing the advertising accounts into one category called "outreach" resulted in a false statement, we see no *unfair* prejudice that could have come from the challenged testimony.

F. *Denials of Motions for New Trial and for Directed Verdict and Acquittal*

Finally, Calhoon challenges the district court's denial of both his motion for a new trial and his motion for a directed verdict and acquittal. The foregoing discussion disposes of the merits of those challenges. The evidence was clearly sufficient to sustain Calhoon's convictions, so the trial court did not err in denying Calhoon's motions.

The judgment is AFFIRMED.

APPENDIX B

IN THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

No. 95-8171

UNITED STATES OF AMERICA,

Plaintiff-Appellee,

versus

JOHN E. CALHOON,

Defendant-Appellant.

On Appeal from the United States District Court for the Middle District of Georgia

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(Filed Dec. 30, 1996)

ON PETITION(S) FOR REHEARING AND SUGGESTION(S) OF REHEARING EN BANC

(Opinion _____, 11th Cir., 19__, ___ F.2d ___).

Before: KRAVITCH and BIRCH, Circuit Judges, and SCHWARZER*, Senior District Judge.

PER CURIAM:

The Petition(s) for Rehearing are DENIED and no member of this panel nor other Judge in regular active service

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*Honorable William W. Schwarzer, Senior U.S. District Judge for the Northern District of California, sitting by designation.

on the Court having requested that the Court be polled on rehearing en banc (Rule 35, Federal Rules of Appellate Procedure; Eleventh Circuit Rule 35-5), the Suggestion(s) of Rehearing En Banc are DENIED.

ENTERED FOR THE COURT:

/s/ Phyllis Kravitch
UNITED STATES CIRCUIT JUDGE

Supreme Court, U.S.
FILED
JUN 2 1997
OFFICE OF THE CLERK

(2)

No. 96-1557

In the Supreme Court of the United States

OCTOBER TERM, 1996

JOHN E. CALHOON, PETITIONER

v.

UNITED STATES OF AMERICA

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

BRIEF FOR THE UNITED STATES IN OPPOSITION

WALTER DELLINGER
Acting Solicitor General
JOHN C. KEENEY
Acting Assistant Attorney General
LOUIS M. FISCHER
Attorney
Department of Justice
Washington, D.C. 20530-0001
(202) 514-2217

13 pp

QUESTIONS PRESENTED

1. Whether the district court's failure to submit the issue of materiality to the jury warranted reversal under the plain-error rule (Fed. R. Crim. P. 52(b)).

2. Whether petitioner's submission of materially false claims for Medicare reimbursement violated 18 U.S.C. 1001 and 1341 irrespective of any entitlement he might have had to reimbursement if he had submitted truthful claims.

3. Whether petitioner was properly convicted of concealing facts material to his claims for reimbursement.

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ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

BRIEF FOR THE UNITED STATES IN OPPOSITION

OPINION BELOW

The opinion of the court of appeals (Pet. App. A1-A32) is reported at 97 F.3d 518.

JURISDICTION

The judgment of the court of appeals was entered on October 16, 1996. A petition for rehearing was denied on December 30, 1996. Pet. App. B1-B2. The petition for a writ of certiorari was filed on March 31, 1997. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

After a jury trial in the United States District Court for the Middle District of Georgia, petitioner was convicted on eight counts of making false statements to the Department of Health and Human Services, in violation of 18 U.S.C. 1001; and on three counts of mail fraud, in violation of 18 U.S.C. 1341.[1] He was sentenced to 15 months' imprisonment. The court of appeals affirmed. Pet. App. A1-A32.

1. During the period relevant to this case, petitioner was employed by Charter Medical Corporation (CMC), a national hospital chain. Petitioner was responsible for obtaining Medicare reimbursement for a group of CMC psychiatric hospitals. To obtain such reimbursement, CMC filed cost reports with private insurance companies that were under contract with the Department of Health and Human Services (HHS) to help administer the Medicare program. Those private insurance companies served as fiscal intermediaries between the hospitals and HHS. They made periodic payments to CMC throughout the year to satisfy the hospitals' cash requirements. At the end of each fiscal year, CMC filed annual cost reports, delineating the costs that each hospital had incurred. Using those reports, the intermediaries determined the annual amount of Medicare reimbursement due to each CMC hospital under various government regulations and guidelines. The intermediaries then either paid CMC an amount that was due or billed CMC for excessive interim payments. Pet. App. A2-A4.

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[1] The government dismissed two counts under Section 1001, and the jury acquitted petitioner on a third such count. Pet. App. A2.

Under industry practice, a health-care provider's cost statements often include items that the provider claims to be subject to reimbursement but that it knows will likely be disputed by an insurance intermediary. In those circumstances, the provider lists those items as presumptively nonreimbursable and files them "under protest." Because of the volume of cost reports they receive, intermediaries often face difficult resource-allocation decisions in designating items for particular scrutiny, such as a full field audit. In making those decisions, intermediaries necessarily rely in large measure on the veracity of the information supplied by the health-care provider. See Pet. App. A4, A23.

2. Petitioner managed one of two sections at CMC responsible for filing cost reports with the insurance-company intermediaries. Pet. App. A2-A3. His convictions rested on three categories of expenses for which he had sought Medicare reimbursement. First, petitioner sought reimbursement for "royalty fees" that individual CMC hospitals had paid to a separate CMC subsidiary for the right to use the "Charter" name; in so doing, he concealed the fact that the hospitals' "expenses" were payments made to a related corporate entity. See *id.* at A7-A15. Second, petitioner sought reimbursement for interest payments associated with certain other transactions conducted within the CMC corporate family; there too, petitioner failed to disclose that the payments were made to a related company. *Id.* at A7-A8, A15-A17. Finally, petitioner sought reimbursement for CMC's advertising costs—only some of which were reimbursable under Medicare—by falsely characterizing those costs as "outreach" rather than as advertising. *Id.* at A17-A19. Petitioner had told one subordinate at CMC that

"if just one intermediary misses an adjustment because it is called outreach, these general ledgers [on which petitioner had made those mischaracterizations] have served their purpose." *Id.* at A19.

3. At trial, the district court instructed the jury that petitioner's alleged false statements were material as a matter of law. Petitioner raised no objection to that instruction. See Pet. 22. After petitioner was convicted, this Court decided *United States* v. *Gaudin*, 115 S. Ct. 2310 (1995), which held that the element of materiality in a Section 1001 prosecution must be submitted to the jury.

On appeal, petitioner first contended that the evidence had been insufficient to prove that his reimbursement claims were false or fraudulent. The court of appeals noted that the government had failed to prove that the royalty fees and interest payments were nonreimbursable *per se*. Pet. App. A10-A13, A15-A17. With respect to those transactions, however, the court determined that petitioner's reimbursement claims were nonetheless false and fraudulent because he had concealed the common corporate ownership of the entities involved in the transactions, a fact that the Medicare regulations and cost report forms required him to disclose. *Id.* at A13-A17. Similarly, because the "outreach" costs were in fact disguised advertising costs, and because petitioner knew that using a different term would conceal the true nature of those costs, the court determined that those claims were also false. *Id.* at A18-A19.

The court of appeals then turned to the issue of materiality. The court determined that, under *Gaudin*, the district court's failure to submit the issue of materiality to the jury was error. Nonetheless, applying the plain-error standard set forth in

Federal Rule of Criminal Procedure 52(b), see generally *United States* v. *Olano*, 507 U.S. 725 (1993), the court held that the error did not require reversal, because "there is no reasonable argument that the statements at issue here were not material." Pet. App. A22. The court explained that "the intermediaries necessarily rely on the information provided in the cost report to make their reimbursability determinations," that "[t]he cost reports were sufficient to persuade the intermediary to authorize reimbursement without further investigation," and that those reports "therefore[] had the capacity to impair or pervert the functioning of a government agency by misleading the intermediaries." *Id.* at A23 (internal quotation marks omitted).

The court of appeals also rejected petitioner's claim that the standards for Medicare reimbursement are so vague that fraudulent claims for such reimbursement can never give rise to criminal liability. See Pet. App. A19-A21. The court explained that a false or fraudulent request for Medicare reimbursement is unlawful whether or not a truthful request would have stated a valid claim to reimbursement: "[W]hile it is true that a provider may submit claims for costs it knows to be presumptively nonreimbursable, it must do so openly and honestly, describing them accurately while challenging the presumption and seeking reimbursement. Nothing less is required if the Medicare reimbursement system is not to be turned into a cat and mouse game in which clever

providers could, with impunity, practice fraud on the government." *Id.* at A20.[2]

ARGUMENT

1. Under *United States* v. *Gaudin*, 115 S. Ct. 2310 (1995), decided after petitioner's trial, the district court's failure to instruct the jury on the issue of materiality with respect to the Section 1001 counts was error. Petitioner does not, however, directly challenge the court of appeals' factbound determination (see Pet. App. A22) that "there is no reasonable argument that the statements at issue here were not material." Instead, petitioner contends that the court of appeals should not have conducted any form of plain-error review because, in his view, a *Gaudin* error, even in the absence of an objection at trial, is a "structural error" that requires reversal whether or not it "affected the outcome." Pet. 23.

As petitioner recognizes (Pet. 24-25), a similar claim was presented in *Johnson* v. *United States*, No. 96-203, which this Court decided on May 12, 1997. In *Johnson*, the Court rejected that claim and held that, in the absence of a timely objection, a *Gaudin* error is subject to plain-error review under Rule 52(b) of the Federal Rules of Criminal Procedure. The Court therefore held that, contrary to petitioner's position here (see Pet. 22-25), such an error warrants the exercise of remedial discretion only if it "seriously affect[s] the fairness, integrity or public reputation of judicial proceedings." *Johnson*, slip op. 8 (internal quotation marks omitted). The Court determined that the defendant in *Johnson* had failed to establish

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[2] The court of appeals also rejected other challenges to petitioner's convictions and sentence; he does not renew those contentions here.

her entitlement to relief under that standard because the evidence on materiality was "overwhelming" and "essentially uncontroverted," and because the defendant had presented "no plausible argument" that the error had affected the verdict. Slip op. 8-9.

Although this petition presents no direct argument concerning any effect that the error in this case may have had on the verdict, petitioner did make such an argument below. See Pet. App. A21-A23. In that respect, petitioner's claim of plain error is arguably distinguishable from the claim rejected in *Johnson*. That decision does not cast doubt, however, on the validity of the court of appeals' judgment here; to the contrary, it supports it. The court of appeals (see *ibid.*) rejected petitioner's *Gaudin* claim because he had not demonstrated any reasonable possibility that a properly instructed jury would have failed to find that the materiality element was met. In particular, petitioner's false reimbursement requests easily satisfied the definition of materiality because they had "a natural tendency to influence, or w[ere] capable of influencing, the decision of the decision-making body to which [they were] addressed." *Kungys* v. *United States*, 485 U.S. 759, 770 (1988); see Pet. App. A22.

Although the court appeared to decide this case under the "substantial rights" component of plain-error analysis rather than under the "discretionary" component that was dispositive in *Johnson*, see Pet. App. A22; compare *Johnson*, slip op. 7-9, the court's inquiry into the effect of the *Gaudin* error on the verdict (see Pet. App. A22) is indistinguishable from the inquiry required as part of that discretionary analysis. See *Johnson*, slip op. 8-9. For that reason, a remand in light of *Johnson* is unnecessary. Nothing

in *Johnson* requires reversal of a conviction in the absence of a "plausible argument" (slip op. 9) that an instructional error, to which no objection was made at trial, did have some effect on the verdict.

2. Petitioner also contends (see Pet. 25-29) that an individual may never be prosecuted for filing false and fraudulent claims for Medicare reimbursement if the expenses claimed were actually incurred. Petitioner argues that, because eligibility for Medicare reimbursement is often a complex inquiry, such prosecutions would deprive Medicare claimants of fair notice of the legality of their conduct. That argument is without merit. Petitioner was prosecuted and convicted not (as he suggests) because he submitted requests for reimbursement to which his company may not have been entitled, but because, in submitting those requests, he distorted and fraudulently concealed facts material to the question of eligibility. Petitioner cites no case, and we are aware of none, holding that uncertainty about a claimant's underlying entitlement to reimbursement removes a fraudulent claim for such reimbursement from the scope of criminal liability. See *United States* v. *Meuli*, 8 F.3d 1481, 1485 (10th Cir. 1993) (under Section 1001, false statement is material if it "influenced the possibility that an * * * investigation would ensue"), cert. denied, 511 U.S. 1020 (1994); *United States* v. *McIntosh*, 655 F.2d 80, 83 (5th Cir. 1981) (similar), cert. denied, 455 U.S. 948 (1982); *United States* v. *Allard*, 926 F.2d 1237, 1242 (1st Cir. 1991) (under Section 1341, "[t]he relevant inquiry is whether there was an intent to mislead the victim by inducing an uninformed consent to part with money or property," not whether "the intended victim was actually defrauded"); cf. *United States* v. *Race*, 632

F.2d 1114 (4th Cir. 1980) (reversing conviction under Section 1001 because prosecution had not proven falsity of claim).

3. Finally, petitioner contends (Pet. 29-30) that, because his conviction on certain counts is based on a theory of concealment, and because (he alleges) the issue of concealment appeared neither in his indictment nor in the relevant portion of the jury instructions, he "stands convicted for something he was neither alleged nor proven to have done." As an initial matter, that claim is not properly before this Court, because petitioner did not raise it in the court of appeals until his petition for rehearing, and that court did not address it.

In any event, the indictment did charge that petitioner had "concealed the true nature of the expenses * * * for which [he] claimed reimbursement," Indictment, p. 4 (Count One, alleging violation of Section 1341), and the district court specifically instructed that "[a] statement or representation may * * * be false or fraudulent when it constitutes a half truth or effectively conceals a material fact with intent to defraud," Sept. 23 & 26, 1994 Tr. 70.[3] Thus, to the extent that petitioner contends that the jury was not properly instructed on the issue of concealment, his claim is incorrect. To the extent that he contends that he had no legal duty to disclose the facts that he concealed, cf. *United States* v. *Tobon-Builes*, 706 F.2d 1092, 1096-1097 (11th Cir. 1983), the court of appeals

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[3] Although the district court placed that instruction within a set of instructions relevant to Section 1341, it had earlier identified "false or fraudulent statement[s]" as the subject of an offense under Section 1001 as well. Sept. 23 & 26, 1994 Tr. 68-69.

correctly rejected that factbound claim. See Pet. App. A13-A21. Finally, to the extent that petitioner tacitly (and erroneously) claims an improper variance between the indictment and the proof at trial, he identifies no resulting prejudice and therefore no basis for reversal. See, *e.g.*, *United States* v. *Jones*, 913 F.2d 1552, 1560 (11th Cir. 1990) (citing *Kotteakos* v. *United States*, 328 U.S. 750 (1946)).

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

WALTER DELLINGER
Acting Solicitor General
JOHN C. KEENEY
Acting Assistant Attorney General
LOUIS M. FISCHER
Attorney

JUNE 1997